Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 September 2023
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risk Register
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Steve Moore, Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

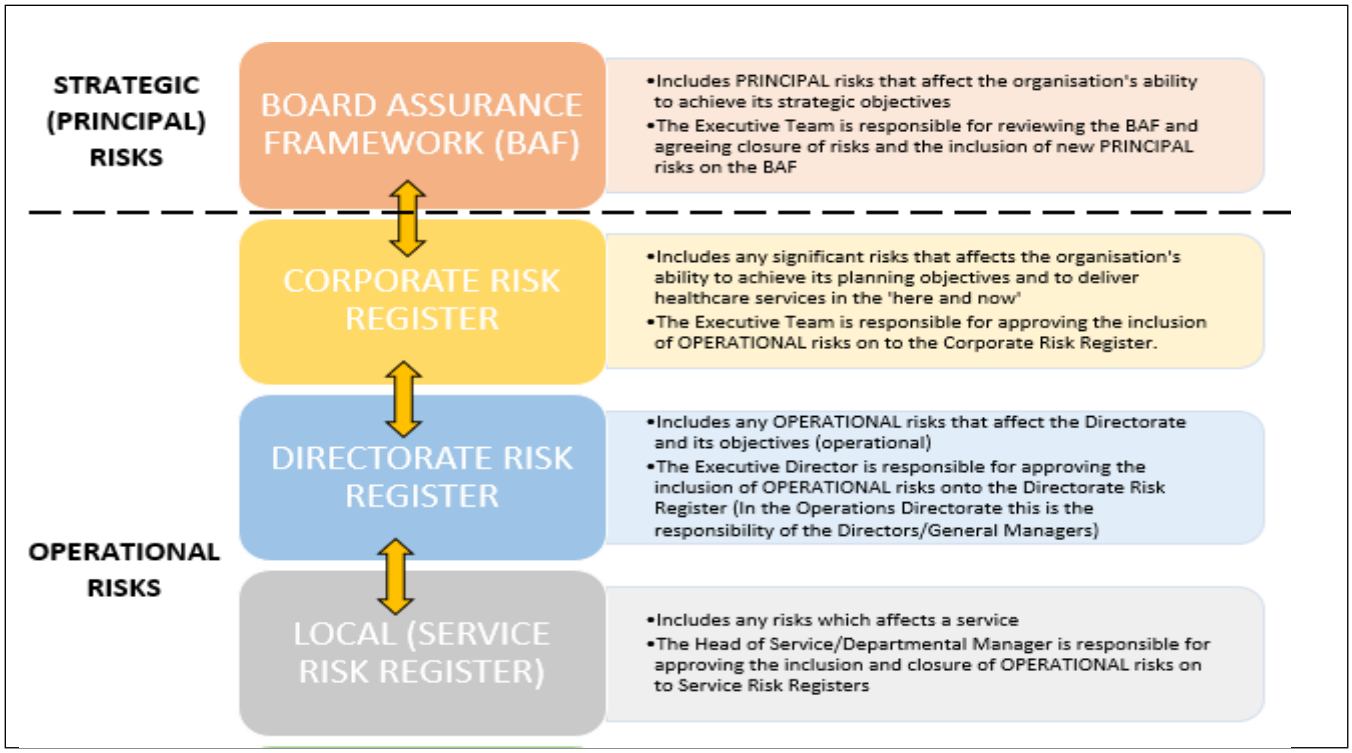
The Corporate Risk Register (CRR) is presented to the Board to advise of the corporate risks of Hywel Dda University Health Board (the Health Board) and provide assurance that these risks are being assessed, reviewed and managed appropriately/effectively.

Cefndir / Background

Risk management is a key component of the governance framework, and should underpin organisational strategy, decision-making and the allocation of resources; as such the organisation is required to have effective risk management arrangements in place. The Board should receive sufficient and timely assurance information on the management of risk to enable it to exercise good oversight.

The Executive Directors, through the monthly Executive Risk Meeting, are responsible for reviewing and discussing their corporate risks, and agreeing any new risks and the escalation/de-escalation of operational risks that are on directorate risk registers. It is the role of the Executive Directors to review controls and ensure appropriate action plans are in place, which might include the development of corporate risk management strategies to manage risk(s). Effective management of these risks enables the organisation to improve its chances of success and reduce the likelihood of failure.

The CRR includes significant risks that affect the organisation's ability to deliver healthcare in the 'here and now' and its ability to achieve its planning objectives (linked to directorate objectives). This is how the Corporate Risk Register interacts with the principal risks on the Board Assurance Framework and the operational risks that are on Directorate and Service risk registers.



Asesiad / Assessment

Since the CRR was previously presented to the Board in May 2023, the risks have been discussed in detail at its Board Committees and reported to the Board via the Committee Update Reports. Where assurance has not been received that corporate risks are being managed effectively, the Committees can request a more in-depth report at a subsequent meeting.

The CRR includes significant risks associated with delivering the 'here and now', whilst the Board Assurance Framework (BAF) will identify the Health Board's principal risks to achieving its strategic objectives, and these will be long term in nature. The BAF dashboard is reported to every other Board meeting.

The following changes have taken place since the CRR was previously presented to the Board in May 2023:

Total Number of Risks as at September 2023	22	
New/Escalated	6	*See note 1*
De-escalated/Closed	2	*See note 2*
Increase in risk score ↑	2	*See note 3*
Reduction in risk score ↓	0	
No change in risk score →	14	

Attached to this report to provide the Board with assurance on the management of its corporate risks are:

Appendix 1 - CRR Summary
Appendix 2 - Each risk detailing the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances.

Due to the sensitive nature of the following risks, the detail is being reported to In-Committee Board, to provide discussion and assurance:

- 1719 (Risk of loss of Radiology services across the Health Board from 31 March 2025 due to delayed implementation of RISP);
- 1352 (Risk of business disruption and delays in patient care due to a cyber-attack); and
- 1328 (Risk of harm to staff, patients and critical assets due to insufficient physical security measures).

Details on the 19 remaining corporate risks are included in Appendix 2.

The 22 corporate risks are detailed on the below heat map:

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5	1382 (NEW)	1531 (→)	813 (→)	1027 (→) 1657 (→) 1664 (NEW) 1719 (NEW)	1642 (↑) 1699 (NEW)
MAJOR 4		1707 (NEW)	684 (→) 1350 (→) 1433 (→) 1559 (→)	1328 (↑) 1352 (→) 1649 (→)	1032 (→) 797 (→)
MODERATE 3			1335 (→) 1548 (↓)	1708 (NEW)	
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in May 2023, 4 new and 2 escalated risks have been added to the CRR:

Risk	Lead Director	New / Escalated	Current Risk Score (LxI)	Rationale for Current Risk Score
1699 – Risk of loss of service capacity at Withybush General Hospital (WGH) due to surveys and remedial work relating to Reinforced Autoclaved Aerated Concrete	Director of Operations	New	**5x5=25**	The risk was approved by Executive Risk Group via Chair's Action on 27 July 2023, reviewed on 6 September 2023 at Executive Risk Group, and further updated by service leads on 12 September 2023. All RAAC affected inpatient wards vacated as of 25 August 2023. Visual surveys are complete in Wards 8/CCU, 10 & 11 with detailed surveys underway. Surveys undertaken on Wards 9, 12 & 7 have identified urgent remedial work to be undertaken, with works scheduled to complete in all three areas by 24 December 2023. Inpatient elective surgery, as would ordinarily be delivered from Ward 9 & Day Surgery Unit, are currently suspended as of June & August 2023 respectively. Medical patients will withdraw from the DSU footprint when Ward 9 reopens in early October 2023. This will enable elective day surgery to recommence on site. It is expected that medical patients will withdraw from the Pembrokeshire Haematology & Oncology Day Unit (PHODU) in November following reopening of Ward 12. This will enable reinstatement of full service to PHODU. Remedial works on Wards 8/CCU, 10 & 11 are scheduled to commence in January and complete in March 2024. Visual survey in Outpatients A has identified significant RAAC related issues (P1 planks) which will likely require works prior to reoccupation, report awaited

				from structural engineers. Impact of this on outpatient activity currently being scoped.
1664 - Risk to Ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Director of Operations	Escalated (risk originally identified 23/05/23)	**4x5=20**	The risk was approved by Executive Risk Group on 2 August 2023. Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional age-related macular degeneration (AMD) sessions on a weekend; however these additional sessions have not been enough to meet the demand across all counties in the Health Board. Patient delays continue across the Health Board. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet AMD was incorporated into the Integrated Medium Term Plan (IMTP) however there has been no additional funding allocated. The current impact has been scored as 5 because patients suffering irreversible sight loss or damage is a reality and the current likelihood has been scored 4 as ophthalmology is a fragile service. It is unlikely that the Board tolerance score of 6 will be achieved without a regionally agreed solution.

1719 - Risk of loss of Radiology services across the Health Board from 31st March 2025 due to delayed implementation of Radiology Information Systems Procurement (RISP)	Director of Operations	New	**4x5=20**	Detail provided to Board in-committee.
1708 - Risk of increasing fragility in primary care contractor services due to challenges recruiting clinicians into salaried roles	Director of Primary Care, Community & Long Term Care	New	**4x3=12**	The risk was approved by Executive Risk Group on 2 August 2023. Dental: current contract discussions and implementation of contract reform has led to a destabilisation of NHS Dentistry in Hywel Dda. Community Pharmacy: inability to secure locums and rising locum costs have impacted on the delivery of services and led to branch closures; in addition, there have been some changes with the multiple groups that have had some impact on service provision.
1707 - Risk of breaching Capital Resource Limit (CRL) in 2023/24 due to additional significant demands for funding	Director of Strategy and Planning	New	**2x4=8**	The risk was approved by Executive Risk Group on 2 August 2023. The Health Board's CRL is under significant pressure due to the fact that the Health Board is currently underwriting the overspend on WGH Phase 1 Fire Schemes along with picking up the cost of the RAAC survey and remedial works. The Health Board has already had to review its approved capital programme for 2023/24 to manage these costs in the short term. Without any additional capital support from Welsh Government (WG) for these schemes, it remains likely that

				the Health Board will breach it's CRL and be unable to deal with emergency issues and breakdowns as they arise in year. WG confirmation has now been received for WGH Phase 1 Fire Schemes and RAAC remedial works in WGH.
1382 - Risk to patients and staff due to a lack of assurance of safe estate as a consequence of RAAC (WGH)	Director of Operations	Escalated (risk originally identified 19/04/19)	**1x5=5**	The risk was approved by Executive Risk Group via Chair's Action on 30 August 2023, and reviewed on 6 September at Executive Risk Group with a risk score of 20. The risk has been further updated by service leads on 13 September 2023 to reflect the mitigating actions now in place, and will be reviewed at Executive Risk Group in October 2023 in light of the revised risk score. The Health Board has engaged specialist structural engineers Curtins to undertake plank by plank visual surveys across WGH which has uncovered a small number of planks that pose a significant risk to safety in 2 wards at WGH. All compromised wards have been decanted as at September 2023, and areas have been secured with authorised access only allowed via keypad entry systems. Other ground floor areas have been fully propped and signed off by the structural engineers as being safe to occupy. Detailed inspection of the planks, to support the work of the visual inspections undertaken to date, are due to commence in October 2023. In addition, assurance has been received on propping design and weekly checks of props are in place. For areas that have yet to be propped, these have been locked off with restricted access. Project plans are in place in terms of when remedial

				actions will be undertaken, and capital has been secured to fund these works. It is envisaged that all wards will be re-occupied by March 2024. Remedial works on other areas are due to commence in April 2024, with a view to completion by September 2023.

Note 2 – De-escalated / Closed Risks

Since the previous report to Board in May 2023, 1 risk has been closed and 1 risk has been de-escalated from the CRR:

Risk	Lead Director	Closed / De-escalated	Date of closure	Reason
129 - Risk to the ability to deliver urgent Primary Care Out Of Hours (OOH) Service due to current service model and recruitment difficulties	Director of Operations	Closed	03/08/2023	The fragility of out of hours is incorporated in the corporate risk relating to the unscheduled care system. A new directorate level risk has been added to supersede this risk (1700 - Risk of inability to deliver a sustainable OOH service due to service fragility).
1340 - Risk of avoidable harm for Health Board patients requiring NSTEMI pathway care	Director of Operations	De-escalated	05/07/2023	It was agreed at Executive Risk Group held on 5 July 2023 to de-escalate, as the reinstatement of the Prince Philip Hospital (PPH) Treat and Repatriate Pathway in April 2023 has positively impacted on the management of this risk. The risk was also discussed at the Improving Together session held in June 2023. Performance will continue to be monitored.

Note 3 – Increase/decreases in Current Risk Score

Since the previous report to Board in May 2023, there have been changes to the scores of the following 2 risks:

Risk	Risk Owner	Previous Risk Score	Risk Score Sept 2023	Date risk identified	Rationale for Current Risk Score

1642 - Risk of Health Board not meeting statutory requirement to break even 23/24 due to significant deficit position	Director of Finance	**4x4=16**	**5x5=25** ↑	13/04/2023	The draft Annual Plan for 2023/24 of £112.9m is unacceptable WG and has led to a further deterioration in an already unsupportable underlying deficit position which will impact future years. The Board have been involved in the discussions and decisions in the development of the 2023/24 Plan both through our Committees of the Board, Board Seminar sessions, and Public Board meetings. As a consequence of these on-going discussions and decisions, the Board, at its meeting on the 30 March 2023, approved the annual plan for 2023/24, recognising the forecast financial outturn remains unacceptable and in breach of the Health Board's statutory requirement to achieve financial balance; further work will be required during 2023/24 to improve the position. At the Board meeting on 30 March 2023 it was also noted that without further support, at this stage, the Health Board will require further cash-backed support from WG as the extent of our cash allocation will be insufficient to continue to service our liabilities as they fall due after early February 2024. The Health Board was placed in WG's Targeted Intervention level of escalation on 29 September 2022, partly relating to our financial position; the 2023/24 Plan presents a deterioration in both the in-year and underlying financial position since 2022/23. Through our 2023/24 planning process, operational plans to address the financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory. Without further support, at this stage, the Health Board will require further cash-backed support from WG as the extent of our cash allocation will be insufficient to continue to service our liabilities as they fall due after early February 2024. If this support is unavailable, which is a risk given the National financial position, then this could affect patient services and our key stakeholders.

1328 - Risk of harm to staff, patients and critical assets due to insufficient physical security measures	Director of Nursing, Quality	**4x3=12**	**4x4=16** ↑	22/12/2021	Detail provided to Board in-committee.

Argymhelliad / Recommendation

The Board is asked to:

- **CONSIDER** whether it has sufficient assurance that corporate risks are being assessed, managed and reviewed appropriately/effectively through the risk management arrangements in place, noting that these have been reviewed by Board level Committees;

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Included within the body of the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Corporate Risk Register
Rhestr Termau: Glossary of Terms:	Current risk score – Existing level of risk taking into account controls in place. Target risk score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented. Risk appetite can be defined as '*the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009). ISO (2009) define risk tolerance as '*the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives*', however it can be simpler to see it as a series of limits such as lines in the sand beyond which the organisation does not wish to proceed.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Risg: Risk:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Cyfreithiol: Legal:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Enw Da: Reputational:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Gyfrinachedd: Privacy:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Cydraddoldeb: Equality:	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.

CORPORATE RISK REGISTER SUMMARY SEPTEMBER 2023

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Sep-23	Trend	Target Risk Score	Risk on page no...
1642	Risk of Health Board not meeting statutory requirement to break even 23/24 due to significant deficit position	Thomas, Huw	Finance inc. claims	6	4x4=16	**5×5=25**	↑	**3×4=12**	6
1699	Risk of loss of service capacity at WGH due to surveys and remedial work relating to RAAC	Carruthers, Andrew	Service/Business interruption/disruption	6	N/A	**5×5=25**	*New*	**2×5=10**	11
1719	Risk of loss of Radiology services across the Health Board from 31st March 2025 due to delayed implementation of RISP *(reported to In-Committee Board)*	Carruthers, Andrew	Service/business interruption/disruption	6	N/A	**4×5=20**	*New*	**2x10=10**	N/A
1657	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 23/24 due to demand exceeding capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	**5×4=20**	→	**3×4=12**	14
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	**4×5=20**	→	**3×4=12**	17
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	**5×4=20**	→	**3×4=12**	22
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	8	5×4=20	**5×4=20**	→	**3×4=12**	29
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	**4×5=20**	*New*	**2×5=10**	33
1649	Risk of insufficiently skilled workforce to deliver services in Annual Plan 23/24 due to limited labour market	Gostling, Lisa	Workforce/OD	8	4×4=16	**4×4=16**	→	**3×4=12**	38
1352	Risk of business disruption and delays in patient care due to a cyber attack *(reported to In-Committee Board)*	Thomas, Huw	Statutory duty/inspections	8	4×4=16	**4×4=16**	→	**3×4=12**	N/A
1328	Risk of harm to staff, patients and critical assets due to insufficient physical security measures *(reported to In-Committee Board)*	Rayani, Mandy	Safety - Patient, Staff or Public	6	3×4=12	**4×4=16**	↑	**3×2=6**	N/A
813	Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	Carruthers, Andrew	Statutory duty/inspections	8	3×5=15	**3×5=15**	→	**1×5=5**	46
684	Risk to the timely investment and replacement of Radiology equipment	Carruthers, Andrew	Service/Business interruption/disruption	6	3×4=12	**3×4=12**	→	**2×4=8**	52
1350	Risk of not meeting the 75% waiting times target for 2022 - 2026 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	8	3×4=12	**3×4=12**	→	**2×4=8**	55
1433	Risk to the ability to maintain routine and emergency services in the event of a severe pandemic	Gjini, Ardiana	Service/Business interruption/disruption	6	3×4=12	**3×4=12**	→	**2×4=8**	58
1708	Risk of increasing fragility in primary care contractor services due to challenges recruiting clinicians into salaried roles	Paterson, Jill	Service/Business interruption/disruption	6	N/A	**4×3=12**	*New*	**2×4=8**	61
1559	Risk of power outages across all clinical and corporate functions of the Health Board due to external influences	Gjini, Ardiana	Safety - Patient, Staff or Public	6	3×4=12	**3×4=12**	→	**2×4=8**	65
1548	Risk to the Health Board maintaining service provision due to industrial action	Gjini, Ardiana	Safety - Patient, Staff or Public	6	3×4=12	**3×4=12**	→	**2×3=6**	68
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	2×5=10	**2×5=10**	→	**2×5=10**	71
1335	Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure	Carruthers, Andrew	Quality/Complaints/Audit	8	3×3=9	**3×3=9**	→	**2×3=6**	74
1707	Risk of breaching Capital Resource Limit (CRL) in 2023/24 due to additional significant demands for funding	Davies, Lee	Statutory duty/inspections	8	N/A	**3×4=12**	*New*	**2×4=8**	77
1382	Risk of harm to patients and staff at WGH due to remedial work relating to RAAC	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	**1x5=5**	*New*	**1x5=5**	80

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days.	Increase in length of hospital stay by >15 days.	An event which impacts on a large number of patients.
			Agency reportable incident.	Mismanagement of patient care with long-term effects.	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.
		Minor implications for patient safety if unresolved.	Major patient safety implications if findings are not acted on.		
		Reduced performance if unresolved.			
Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.

Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Inequalities/ Equity	Minimal or no impact on our attempts to reduce health inequalities/improve health equity	Minor impact on our attempts to reduce health inequalities or lack of clarity on the impact we are having on health equity	Moderate impact on our attempts to reduce health inequalities or lack of sufficient information that would demonstrate that we are not widening the gap. Indications that we are having no positive impact on health improvement or health equity	Major impact on our attempts to reduce health inequalities. Validated data suggesting we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity

RISK MATRIX

	LIKELIHOOD →				
IMPACT ↓	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

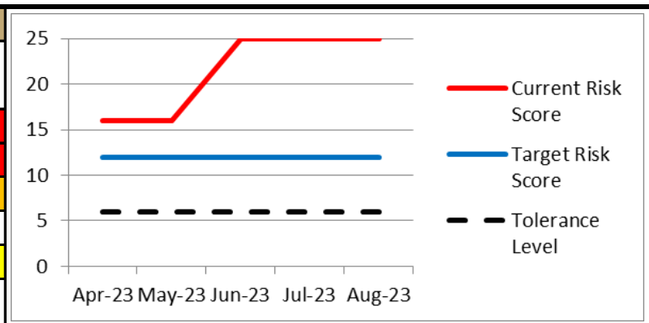
RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	**Extreme**	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	**High**	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	**Moderate**	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	**Low**	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Date Risk Identified:	Apr-23	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Sep-23
Strategic Objective:		**Lead Committee:**	Sustainable Resources Committee	**Date of Next Review:**	Oct-23

Risk ID:	**1642**	**Principal Risk Description:**	There is a risk that the Health Board deficit is unaffordable for Welsh Government This is caused by the Financial Plan for 2023/24 presenting a significant deficit position, which reflects the significant step-change in expenditure during COVID-19. This has persisted, as operational pressures have remained; and a further step-change in expenditure is expected into next year, arising, largely, from inflationary pressures. Additional causes include: 1. Insufficient assurance over the identification or operational delivery of the required level of savings in the year because of continued operational and clinical challenges across our services, in particular within urgent and emergency care; 2. Further in-year operational cost deterioration either due to operational decisions or market price volatility within areas such as Prescribing and Energy. This could lead to an impact/affect on the sustainability of the Health Board's financial position, with a cash funding shortfall and the ability to meet payments as and when they fall due from Q4 2023/24.There will also be an impact on the ability to meet Ministerial priorities of breaking even, along with the ability to maintain patient services.
Does this risk link to any Directorate (operational) risks?			980, 968, 964, 966, 975, 983, 971, 965, 1644, 1646

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The draft Annual Plan for 2023/24 of £112.9m is unacceptable to WG and has led to a further deterioration in an already unsupportable underlying deficit position which will impact future years. The Board have been involved in the discussions and decisions in the development of the 2023/24 Plan both through our Committees of the Board, Board Seminar sessions, and Public Board meetings. As a consequence of these on-going discussions and decisions, the Board, at its meeting on the 30th March 2023, approved the annual plan for 2023/24, recognising the forecast financial outturn remains unacceptable and in breach of the Health Board's statutory requirement to achieve financial balance; further work will be required during 2023/24 to improve the position. At the Board meeting on the 30th March 2023 it was also noted that without further support, at this stage, the Health Board will require further cash-backed support from Welsh Government as the extent of our cash allocation will be insufficient to continue to service our liabilities as they fall due after early February 2024. The Health Board was placed in WG's Targeted Intervention level of escalation on 29 September 2022, partly relating to our financial position; the 2023/24 Plan presents a deterioration in both the in-year and underlying financial position since 2022/23. Through our 2023/24 planning process, operational plans to address the financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory. Without further support, at this stage, the Health Board will require further cash-backed support from Welsh Government as the extent of our cash allocation will be insufficient to continue to service our liabilities as they fall due after early February 2024. If this support is unavailable, which is a risk given the National financial position, then this could affect patient services and our key stakeholders.	The Health Board needs to demonstrate that it is able to manage its financial position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care. The current draft Financial Plan does not provide sufficient assurance of this and urgent management actions are required to address this. Given the challenge in delivering an acceptable financial position this year, it is unlikely that the Health Board will achieve a risk which is in line with the existing tolerable risk of 8 for the year. Consequently, it has been requested of the Board to increase the tolerable risk score to 12 in line with the Target.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. Modelling of anticipated patient flows, and the resultant workforce, equipment and operational requirements is managed through operational teams. 2. Financial modelling and forecasting is co-ordinated on a regular basis. 3. Timely financial reporting to Directorates, Sustainable Resources Committee, Board and Welsh Government on local costs incurred as a result of Operational Drivers to inform central and local scrutiny, feedback and decision-making. 4. Oversight arrangements in place at Board level and through the Executive Team structure. 5. Exploration of a number of funding streams, including: Local Health Board funding arrangements; Funding arrangements through the Regional Partnership Board and Local Authority partners. Funding from WG's own sources or from HM Treasury via WG. 6. Opportunities Framework refreshed with the expectation that identified areas of waste will present deliverable cost reductions/formal savings schemes. Linked to Planning Objectives workplan, which will be shaped by the Health Board's strategy, “A Healthier Mid and West Wales", and align to the design assumptions set out in that. 7. Accountability statements in relation to the Opening Directorate Budgets underpinning the draft interim Financial Plan for 2023/24 will issued to the Executive Team in May 2023. The letters clarify that it is expected that all budget holders manage their services within their allocated budgetary envelope; that it is incumbent on all to ensure that expenditure represents best value; and, that there is the expectation that these operational needs can be clearly demonstrated and that additional costs will reduce as and when decisions are made. 8. Performance against Plan monitored through Improving Together Meetings with Services, including Performance, Quality and Financial information. 9. Implementation of systems for efficiency (Malinko, WellSky, Nurse Documentation system) are driving financial systems for control	The costs of addressing the Health Board's local needs may exceed available revenue and cash funding. The organisation may fail to deliver the required level of transformational change during the year through which the opening cost base is expected to be rationalised. This is in relation to the continuation of core and other services, the direct (programme) response to COVID-19, specific exceptional costs and the delivery of Recovery and Sustainability Plans.	Targeted Intervention working group and escalation Steering Group to discuss, agree and implement corrective actions to respond to Targeted Intervention status.	Moore, Steve	~~30/06/2023~~ 31/08/2023	Through the approval of the Annual Plan the Board has accepted the validity of the current operational drivers and accepted the choices and identified opportunities available to mitigate the current trajectory. The process is in place, however the cycles are yet to identify corrective actions leading to an in-year or future year financial improvement. As these corrective actions are identified, these will be added to the risk Action Plan. A meeting was held with WG week the week of 19th June 2023 where final deadlines and actions were agreed. A further meeting is scheduled with Welsh Government on 11/08/2023 where further actions will be agreed.
	Develop a revised roadmap to financial sustainability based on the Board's agreed key priorities and revised Planning Objectives in line with our Strategy.		Thomas, Huw	~~30/06/2023~~ 31/08/2023	June-23 - A focused Executive Team Away Day in June considered mitigating actions and their delivery; a six week action timetable has commenced. This is the first step towards developing a roadmap and will link to the clinical services plan.

(Symbiotics, Caf M in Facilities and Estates, Allocate), alongside the Digital Strategy improving grip and control. 10. Weekly financial reporting to Executive Team, tracking week-on-week progress against key metrics. 11. Tactical TI Group meets on a fortnightly basis, led by the Director of Finance as SRO. This reports into an escalation Steering Group, which meets on a monthly basis, chaired by the CEO where specific executive leads meet to discuss, agree and implement corrective actions to respond to the escalated Targeted Intervention status that Welsh Government placed the Health Board during October 2022. The weekly Executive Team meeting chaired by the CEO will be the internal group that monitors and drives progress, focusing on: a) delivery of our Planning Objectives and the subsequent financial benefits; b) efficiency and productivity opportunities (based on our Opportunities Framework); c) corrective actions identified through our regular Executive-led Directorate Use of Resources meetings to reduce current expenditure trajectories.		Following the July meeting between the Ministers and Chief Executives, the organisation is required to develop mitigation plans to address the forecast in-year deviation from plans in addition to achieving a 10-20-30% improvement against the submitted financial plan.	Moore, Steve	31/03/2024	A recovery workshop was held on the 26/07/2023 with Executives, service and Finance leads to discuss and agree urgent actions to address the financial position. The meeting focussed on the key driver of high cost agency and locum expenditure across professional groups. Action plans are being developed for presentation to Board on the 10/08/2023 for consideration/decision ahead of the Welsh Government meeting on 11/08/2023.

Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against operational plans and targets through Performance KPIs In-month financial monitoring	Performance against plan monitored through Improving Together Meetings.	1st			* Mth 1 Finance Report Board, May 2023 * Mth 2 Finance Report Sustainable Resources Committee June 2023 * Mth 3 Finance Report Going to Board July 2023	None				
	Sustainable Resources Committee oversight of current performance	2nd								
	Transformation & Financial Report to Board & SRC	2nd								
	WG scrutiny through monthly monitoring returns	3rd								
	WG scrutiny through revised monthly Monitoring Returns (specific supplementary templates) and through Finance Delivery Unit	3rd								
	Audit Wales Structured Assessment process	3rd								

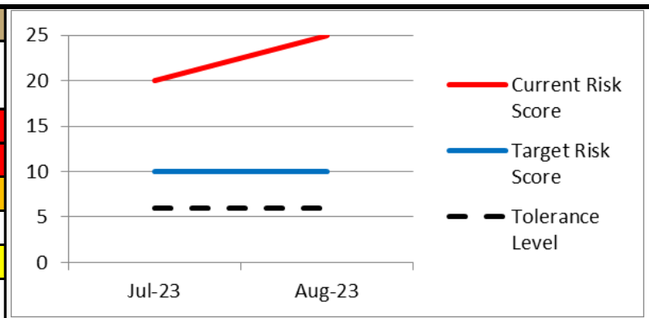
Appendix 2

Date Risk Identified:	Jun-23		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Sep-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Oct-23

Risk ID:	**1699**	**Principal Risk Description:**	There is a risk that there could be a significant loss of capacity to deliver elective, urgent and emergency and outpatient services at Withybush Hospital (WGH), and the delivery of the Health Board's Annual Plan 2023/24. This is caused by by the requirement to undertake surveys and take immediate disruptive remedial works, where necessary, to address findings of reinforced autoclaved aerated concrete (RAAC) surveys at WGH, which may result in a number of wards being concurrently closed whilst surveys and remedial works are undertaken. This could lead to an impact/affect on the ability to safely manage demand across elective, urgent and emergency inpatient and outpatient services, including patients accessing specialist areas for care (including coronary care, complex oncology, gastroenterology, respiratory and stroke), disruption to pharmacy services, and poorer patient outcomes from overcrowding in the Emergency Department resulting in delays in accessing care and treatment. This will affect the Health Board's ability to achieve ministerial priorities as set out in the Annual Plan 2023/24 (eg, improvements to ambulance response times and emergency department waiting times). There may also be increased scrutiny from key stakeholders, including Welsh Government and other regulators which may lead to the loss of public confidence, and increased pressures on current workforce.
Does this risk link to any Directorate (operational) risks?		1382, 1385, 1657, 1027	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	*New risk*



Rationale for CURRENT Risk Score:
Inpatient elective surgery as would ordinarily be delivered from Ward 9 & Day Surgery Unit on site are currently suspended as of June & August 2023 respectively. Surveys undertaken on Ward 12 have identified urgent remedial work to be undertaken, and the ward as of July 2023 is empty. Based on the current number of planks affected, the potential exists for there to be unstable critical planks in areas which continue to be used. Until further survey work is concluded, we will be unable to confirm the extent of red or very high-risk planks in those areas which have not yet been surveyed.

Rationale for TARGET Risk Score:
All RAAC affected inpatient wards vacated as of August 25th 2023. Visual surveys are complete in Wards 8/CCU,10 & 11 with detailed surveys underway. Surveys undertaken on Wards 9, 12 & 7 have identified urgent remedial work to be undertaken, with works scheduled to complete in all three areas by December 24th 2023. Inpatient elective surgery, as would ordinarily be delivered from Ward 9 & Day Surgery Unit, are currently suspended as of June & August 2023 respectively. Medical patients will withdraw from the DSU footprint when Ward 9 reopens in early October 2023. This will enable elective day surgery to recommence on site. It is expected that medical patients will withdraw from the Pembrokeshire Haematology & Oncology Day Unit (PHODU) in November following reopening of Ward 12. This will enable reinstatement of full service to PHODU. Remedial works on Wards 8/CCU,10 & 11 are scheduled to commence in January and complete in March 2024. Visual survey in Outpatients A has identified significant RAAC related issues (P1 planks) which will likely require works prior to reoccupation, report awaited from structural engineers. Impact of this on outpatient activity currently being scoped.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of Cleddau Ward (East & West), in South Pembs Hospital, to reprovide 28 non acute inpatient beds to those meeting a pre-determined criteria Implementation of different model of care in Cleddau Ward to facilitate improved patient flow Emergency pathways, reviews and developments in place to minimise admissions and length of stay (LOS) in hospital Optimising available inpatient capacity, where possible. Suspension of all elective surgery on site pending completion of survey work Maximising use of potential bed capacity in areas across WGH not affected by RAAC. Conveyance avoidance measures in place including clinical triaging of Health Care Professional referrals to secondary care Comprehensive plan in place to undertake planned surveys - contractor on site. Fast Track Visual Surveys complete with detailed plank by plank surveys underway in ward areas. Ground floor areas to commence mid October 2023. Commenced programme of works, Pot Wash area completed and Wards 9 and 12 commenced (planned completion end of September & October respectively). Ward 7 repair works programme due to commence early October 2023 Utilising Acrowprop and/or hybrid measures to mitigate impact and reduce risk until repair works are undertaken Internal and External Communications undertaken and planned approach going forward WGH RAAC Implementation Group, consisting of key estates and service management Business Continuity Incident declared on 15Aug23, and a Command Control Structure (Gold Silver/Bronze) established to coordinate and manage Health Board response.	Clarity on funding streams required to progress remedial works. Health Board Discretionary Capital allocation used to commence works in Wards 9 & 12. Further funding remains unapproved. To continue with this programme at pace is significantly beyond that which can be supported by our Discretionary Programme Clarity on scope and associated timelines of the required remedial works Ability to provide catering on site during and following survey whilst awaiting remedial works Ability to manage impacts from loss of medical bed capacity is more challenging as numbers of bed losses increase and winter approaches Operational position on other sites does not easily support transfer of clinical pathways Ability to transport emergency and non-emergency patients to alternative sites	To explore funding options with Welsh Government to support remedial work	Davies, Lee	~~31/07/2023~~ 30/09/2023	Discussions are ongoing with Welsh Government who have requested estimated costs of works
		To minimise scope and level of disruption as far as reasonably practicable by combining Phase 2 Fire Works with RAACs remedial works, where possible	Chiffi, Simon	~~31/07/2023~~ 30/09/2023	As at July 2023, still awaiting clearance from MWWFRS - meeting scheduled 19 July 2023
		Develop a programme of works at WGH to address survey outcomes	Williams, Paul	30/09/2023	Current timescales suggest that remedial works on Ward 9 will be complete by September 2023, however it is noted that further remedial works may take longer dependant on survey outcomes. Ward 12 full works ot complete end of October 2023. Fast Track Visual Surveys being arranged to identify critical (P1) planks.
		Liaise with affected services and departments to communicate the expected impact of service disruption on their areas	Cole-Williams, Janice	~~31/07/2023~~ 30/09/2023 30/11/2023	Site management to liaise with services to raise awareness of expected disruption in relation to corridors, office & clinical space, as well as supporting service relocation for survey and works as required. This will continue whilst surveys and remedial works are undertaken.
		Reviewing service delivery response and developing contingency plans in the event of losing significant clinical capacity	Carruthers, Andrew	30/09/2023	Work is being undertaken to maximise use of bed capacity in areas across WGH not affected by RAAC, with additional bed capacity being scoped and utilised in South Pembrokeshire Hospital. Currently exploring moving Haematology and Oncology to a different area on site and increasing bed capacity in Puffin Ward. Alternative means of elective surgery provision being explored across Health Board and wider region. Outpatient services switched to virtual if at all possible to release capacity during survey work.

Liaising with other hospital sites in England to understand how they've managed the situation	Scoping alternative catering arrangements for WGH	Elliott, Rob	31/08/2023	To be provided at next risk review

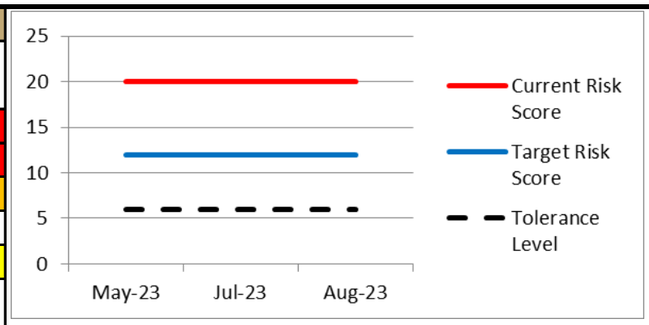
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Project plans in place dependant on outcomes of surveys, and monitored via the WGH RAAC Control Group	Fortnightly WGH RAAC Control Group meetings	1st			RAAC paper to SDODC (Apr 23) RAAC paper to HSC (Jul 2023) RAAC included in Director of Operations Report to Board (Jul23)	Unaware of the extent and impact of the risk until all surveys have been completed	Urgent programme of assessment to be undertaken to assess remaining areas	Elliott, Rob	30/09/2023	Risk assessments currently being undertaken by the Estates and Facilities Directorate on remaining areas, the outcomes of which will assist in the decision on next steps regarding ward closures. Fast track visual inspection commenced to rapidly identify and mitigate risks over the c. 10-week programme
	Command and Control Structure established to coordinate Health Board response	2nd								
	RAAC survey findings by external contractor	3rd								

Date Risk Identified:	May-23		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-23
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Aug-23

Risk ID:	**1657**	**Principal Risk Description:**	There is a risk of non-delivery of ministerial priority expectations in relation to delivery of planned care recovery ambitions through 2023/24. This is caused by by current uncertainty regarding resources available to support recovery actions, the availability of workforce and /or externally provided capacity, and the continuing impact of post-pandemic urgent and emergency care (UEC) pathway pressures (as reflected in risk 1027) which continue to impact upon available capacity for some specialties. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?		1548, 180, 523, 525, 632, 958, 1083, 1027, 1628, 1629	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	*New risk*



Rationale for CURRENT Risk Score:

The combined impact of current uncertainty regarding resources available to support recovery actions, the availability of workforce and /or externally provided capacity and the continuing impact of post-pandemic urgent and emergency care pathway pressures (as reflected in risk 1027) which continue to impact upon available capacity for some specialties, all pose a risk to achievement of ministerial priority expectations in relation to achievement of planned care recovery ambitions. The Annual Plan approved by the Board in March 2023 and supporting performance trajectories highlight significant gaps between the resourced level of capacity reflected in the plan, and the anticipated level of patient demand to be treated during 2023/24. Whilst further proposals have been submitted to WG to access retained recovery funding not yet allocated to health boards, revised delivery trajectories cannot be confirmed without a supporting resource plan. Subject to availability of additional resources to support additional recovery actions, it is anticipated that a significant volume of additional activity will need to be supported by externally provided solutions, either via neighbouring health boards or via the independent sector insource / outsource market. External capacity cannot be confirmed prior to formal market testing. Limits to staffing resource both in theatre, and post operatively, was a challenge before the COVID pandemic. Whilst positive progress has been achieved in increasing outpatient activity & capacity to levels comparable with pre-pandemic volumes, significant staffing deficits within the Anaesthetic medical and theatre staffing teams continues to limit the volume of elective operating sessions undertaken and therefore continues to limit progress in expanding overall activity levels to match/exceed pre-pandemic levels. The continuing legacy of the COVID-19 pandemic on urgent and emergency care pathway demand and the consequential impact on available bed capacity continues to limit sufficient capacity to support activity expansion plans in key specialties. Whilst no health board is currently achieving ministerial milestones in respect of planned care recovery, HDUHB has achieved the greatest progress compared to other health boards across Wales during 2022/23 and has achieved a significant improvement in the volumes of Stage 1 patients waiting > 52 weeks and total pathway patients waiting > 104 weeks.

Rationale for TARGET Risk Score:

Across the UK, there is a significant challenge for health organisations in sustaining the recovery of planned care pathways post pandemic. The target score of 12 is based on the realistic assessment of the level of planned care work which could be achieved both internally across the UHB and via maximum utilisation of capacity available within the independent sector, should available resource levels support commissioning of activity to the level required.

Whilst efforts to make further progress towards the Ministerial Measures continue, the Health Board has signalled through its Annual Recovery Plan that full achievement of both the Stage 1 and Total pathway measures by the respective target dates is unachievable without additional enabling resource to support further recovery actions.

The tolerable risk (6) remains unchanged for the level highlighted during 2022/23 and reflects the longer term recovery ambitions of the Health Board to reduce waiting lists and length of wait to the lowest levels possible.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of dedicated elective beds on 3 sites. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Robust sickness absence management arrangements in place. # Comprehensive programme of outsourcing of planned care volumes in place utilising capacity available via independent sector providers. # Weekly review of outsourcing volumes and further opportunities progressed jointly by Planned Care and Commissioning teams. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Additional Planned Care Recovery proposals submitted to WG May 2023.	# Limited impact to date of the wider urgent and emergency care plan in reducing capacity pressures on acute sites and the ability to protect sufficient elective pathway capacity for elective patients. # Theatre staffing availability to support expansion of theatre capacity at required pace and level. # Timeliness of the All Wales Commissioning Framework to support rapid decision making and commissioning of independent sector activity levels when supported by non-recurrent funding released part-way through the year. # Sufficiency of Health records service capacity to support planned expansion of outpatient activity. # Sufficiency of Anaesthetic medical staffing capacity to support planned expansion of required operating lists.	Elective care delivery plan developed for inclusion within Annual Delivery Plan.	Jones, Keith	Completed	Plan complete and submitted within refreshed Annual Recovery Plan.
		Additional Recovery proposals submitted to WG May 2023 against WG £50m retained Recovery Fund	Jones, Keith	Completed	Additional proposals submitted. Outcome awaited.
		Opportunities to enhance dedicated elective pathway capacity across sites is dependent upon successful delivery of the transforming urgent and emergency care plan.	Jones, Keith	30/09/2023	Partially Complete - Dedicated elective capacity in place at Prince Philip Hospital and Bronglais General Hospital. Availability of dedicated elective capacity at Withybush General Hospital has been delayed until early Q3 at the earliest due to estate infrastructure challenges on the site. However, this remains under review do to the developing RAAC risk assessment work currently underway. Limited dedicated elective pathway capacity at Glangwili Hospital to support sufficient internal capacity for Urology & ENT surgery. Proposals for an alternative configuration of dedicated planned care capacity at Prince Philip Hospital are currently being explored.
		Workforce development and recruitment plan jointly developed between Planned Care & Workforce Team	Hire, Stephanie	~~30/06/2023~~ 30/08/2023	Continued progress achieved in recruitment of theatre staffing and consultant anaesthetic appointments, but levels remained below required WTE. Further review in August 2023.
		Subject to availability of additional resources to support additional recovery actions, access to sufficient external insource / outsource capacity will be dependent upon formal market testing	Hire, Stephanie	~~30/06/2023~~ 30/08/2023	WG allocation of additional recovery resources (confirmed 25 July 23) is significantly below the required level reflected in the Health Board's additional recovery proposals. Impact assessment currently being conducted.

Appendix 2

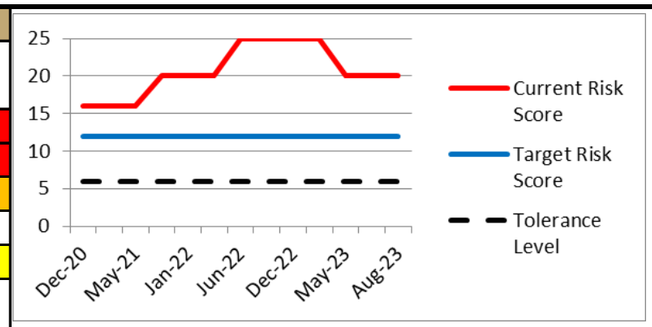
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance indicators. A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st			Annual Plan 2023/24 - Board (Mar23, May23, Jul23)	None				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Acute Services Triumvirate	1st								
	Bi-monthly reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	WG IQPD & Enhanced Monitoring Meetings	3rd								

Appendix 2

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jul-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

Risk ID:	**1027**	**Principal Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?		1406, 1548, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295, 1435, 1377, 1083, 180, 1424, 1417, 1309, 291, 118, 925, 119, 1245, 695	

Risk Rating:(Likelihood x Impact)		
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	5×5=25	
Current Risk Score (L x I):	4×5=20	
Target Risk Score (L x I):	3×4=12	
Tolerable Risk:	6	
Trend:	⟷	



Rationale for CURRENT Risk Score:
Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. This is driven by post pandemic demand and the broader impacts of COVID-19. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating significantly worrying trends. The indirect legacy of the pandemic has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis. During recent months, increased levels of COVID-19, Influenza, respiratory disease and norovirus has placed additional pressure on available capacity. Notwithstanding these challenges, positive progress has been achieved since January 2023 in reducing peak levels of pressure with notable improvements achieved in key urgent and emergency care (UEC) pathway metrics relating to ambulance handover and emergency departments (ED) waiting times. Progress remains consistent with small incremental improvements, and as at May 2023 the risk score was reduced to 20 based on likelihood, and remains as at July 2023.

Rationale for TARGET Risk Score:
There is a significant challenge across the Urgent and Emergency Care system. The combined impact of the multi-faceted pressures which underpin this risk have led to an incremental increase in the overall level of pressure as reflected in deteriorating delays for ambulance handover, access to urgent and emergency care and delayed discharges. The extent to which these combined pressures impact upon the timeliness and quality of care provided is related to the overall availability of staffing resources on a daily / weekly basis, which in turn is influenced by increasing levels of staff sickness/absence. In light of the positive progress achieved in since January 2023 in reducing peak levels of pressure with notable improvements achieved in key UEC pathway metrics relating to ambulance handover and ED waiting times, this risk and target risk score will be reviewed and revised for 2023/24.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation which include efficient handover from WAST into ED. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles and specifically reviews COVID-related absence and forward forecast. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Winter Plans developed to manage whole system pressures. # Joint workplan with Welsh Ambulance Services NHS Trust. # 111 implemented across Hywel Dda. # Transformation fund bids in relation to crisis response being implemented across the Health Board. # IP&C support for care homes to avoid outbreaks. # Ability to deploy Health Board staff where workforce compromise is immediately threatening to continuation of care for residents. # Care Home Risk & Escalation Policy to be applied to support failing care homes as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across Health Board # COVID-19 IP&C Outbreak policy in place to coordinate management of infection outbreaks, led by site HoNs (supported by IP&C teams). # Integrated whole system, urgent and emergency care plan agreed. # Establishment of a Discharge to Assess (D2A) Group which reports to the Unscheduled Care group. # Establishment of a D2A Escalation Transfer panel which provides senior oversight of delays, assesses risk of the delay to the patient and organisation in terms of flow compromise # To optimise step down bed capacity in the community across care homes and community hospitals # SRO in place to lead agreed Urgent and Emergency Care (UEC)	# Fragility of Care Home Sector exacerbated by COVID related issues such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff # Nurse staffing availability to ensure safe levels of care as a consequence vacancies. # Post-COVID-19 fatigue is exacerbating workforce capacity and availability of bank and agency staff who would be available. # COVID-19 incidence continues to further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Inability to offload ambulances to release them back for use within community. # Increased pressures at ED as a result of WAST ambulance response policy resulting in very poorly patients self-presenting. # Better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance # Effective and timely communication to the public at times of pressure but also of safe alternatives to hospital admission / ED presentation that will contribute to changing public mind set / expectation and culture in terms of use of NHS resource and 'Home First' # Education and training for best practice in frailty management mandated to effect culture of 'unsafe to admit' for our very / severely frail # Supporting staff to be able to better manage family dispute relating to expectation eg home of choice,	Create live UEC performance dashboard.	Matthews, Rhian	Completed	UEC live performance dashboard in place.
		Recruitment to UEC Programme Management Office	Matthews, Rhian	Completed	Recruitment process complete.
		Implementation of 111 First and local streaming hub as well as enhancing Same Day Emergency Care (SDEC) provision to reduce conveyance and conversion	Matthews, Rhian	Completed	Fully recruited to existing scheme
		Explore and gain approval for funding for 2wte COTE consultants	Matthews, Rhian	Completed	Completed
		To implement the Standard for Discharge to Assess in accordance with the WG Discharge Guidance	Matthews, Rhian	Completed	Plan to be developed.
		To consider alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs	Matthews, Rhian	Completed	Pending confirmation indemnity for the local GPs to deliver.
		Refer CRR 1649 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2024	Ref CRR 1649 for detailed progress.
		To undertake a quality improvement project to map flow across GGH unscheduled system supported by Improvement Wales.	Perry, Sarah	~~31/12/2022~~ 31/12/2023	Work is ongoing, and being rolled out to PPH and BGH
		To codesign schemes with Local Authorities that put urgent capacity into the system to reduce bed occupancy rate for frail, complex patients	Lorton, Elaine	Completed	Work concluded in March 2023, action therefore completed.
		Review extant Escalation Policy to incorporate the whole UEC system	Jones, Keith	Completed	HB Escalation Policy reaffirmed. Sites regularly operating at Red (Level 4) status with limited non-urgent elective surgery undertaken at the four sites due to urgent and emergency care pressures.
		Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan.	Matthews, Rhian	31/03/2025	Launch of the UEC Improvement Programme on 16/06/22 to galvanise a collective approach to improvement, and ongoing as at May 2023.

programme # Supernumery HCSWs aligned to the acute response teams to support failing community care capacity # Support for complex discharge caseload management tool (SharePoint) appointed # Reminders issued to management on importance of robust management of staff sickness and the use of COVID-19 Risk Assessment to help manage staff absences. # SDEC models continuously reviewed and refined to maximise impact on admission avoidance. # Staff are encouraged to participate in the UHB's ongoing COVID-19 vaccination programme. # Alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs. # Service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays. # Increased bedding capacity in community hospitals. # UEC live performance dashboard in place. # Local streaming hub. # Direct referral into SDEC in WGH, GGH and PPH. # Operational joint meeting with WAST to identify and taking forward key action to help address conveyance. # Clinical Streaming Hub includes APP Navigator working with Physicians to triage and stream patients pending conveyance to more appropriate pathway in the community (In Hours).	transfer pathways to short term placement in care home pending home care availability # Development of a 'tool' that supports staff to assess risk across the whole system to support decision making when discharge appears to be 'risky' to the individual patient. This includes decision making for 'further rehabilitation required in the acute environment' (why not at home?), further blood analysis to confirm medically fit to discharge, home care not available but family happy to take in the interim. # For all patients with LOS > 21 days the need for escalation and 'senior think tank' # If there is a paucity of home care to the extent that we are unable to provide > 28 hours per week (calls four times per day) - why are we advocating this level of commissioning? # Clarity regarding roles and responsibilities for discharge planning and coordination # The availability of live data at Cluster, County and Site level with sufficient analytical support # the ability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission # Optimising our bedded facilities in the community i.e we should aim for 'step up' from community and from 'front door' hospitals (within 72 hours) rather than as a 'step down' from acute hospitals after long length of stay. LOS should be no more than 10 days # Bespoke recruitment targeted at critical posts that will deliver	Review wider nursing establishment requirements across 25A wards (outside of NSLA) to support increasing capacity and environments for patients.	Passey, Sian	Completed	Complete - All wards have been reviewed and will continually be reviewed, throughout the nurse staffing cycles and through the workforce stabilisation meetings Chaired by workforce, these meeting include each site and consider all wards and services nurse staffing. Additional capacity has been created in Amman Valley. An Alternative Care Unit Y Lolfa became operational in November on the GGH site, with the focus on complex discharges and prevention of further de-conditioning of patients. There are close working relationships with Home First Teams and other based community teams with the purpose of supporting discharge of complex patients into the community at the earliest opportunity. Review of nursing models within EDs will continue through the nurse stabilisation meetings now established.
		To review the West Wales Care Partnership Regional Discharge 2 Assess policy and develop action plan to ensure effective implementation of Policy Goal 5 (optimal hospital care following admission)	Passey, Sian	Completed	Confirmed as complete by Rhian Matthews on 02/12/2022
		Review ambulance handover procedure in conjunction with WAST and HB Review Escalation Policy	Passey, Sian	Completed	The Ambulance Hand over policy which has been updated in collaboration with WAST has now been ratified. An updated self - assessment in relation to recommendations received from HIW has been submitted to WAST in October. Partnership working with WAST and other colleagues continues to address hand over delays and this is being taken forward through TUEC work streams

improvements in UEC eg ANPs, APPs, PAs etc. and accept risk to permanently fund such posts i.e should not be temporarily funded. # Frailty screening by staff in ED and reporting into WPAS to support risk stratification of patient cohorts who should spend no more than 10 days in hospital. Majority should be turned around in 12 hours and < 72 hours. # Frailty screening and reporting into WPAS of inpatients who either have formal care in place on admission or whose level of frailty on admission suggests a need for care and support on discharge. This will support risk stratification to support discharge planning and coordination. # Consideration of workforce development for existing staff but also bespoke opportunities for non clinical roles that releases clinical time for 'clinicians to only do what they can do' # Reduce service duplication across sites # Inconsistent clinical provision for the Out of Hours (OOH) Service # Development of 24/7 urgent primary care service that integrates urgent primary care service in the day and GPOOH and provides timely information, advice and assistance to patients and clinicians to provide safe alternatives to hospital admissions.	Review Escalation Policy	Jones, Keith	Completed	HB Escalataion Policy reaffirmed. Sites regularly operating at Red (Level 4) status with limited non-urgent elective surgery undertaken at the four sites due to urgent and emergency care pressures.
	Review nursing models to support increasing capacity and environments for patients	Passey, Sian	Completed	Continuous discussions with Heads of Nursing and regular operational consideration given to scoping patient profile and pathways. In conjunction with primary care colleagues additional capacity in Amman Valley Hospital.
	Explore service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays	Matthews, Rhian	Completed	Completed.
	Recruit additional workforce in line with safe staffing requirements for 28 beds in Amman Valley Hospital	Matthews, Rhian	Completed	Completed.
	Development of enhanced Bridging Service and to actively recruit HCSWs to support domiciliary care services	Lorton, Elaine	Completed	Completed.
	To implement the Standard for Discharge to Assess in accordance with the WG 6 Goals Guidance	Matthews, Rhian	~~31/07/2023~~ 31/03/2024	New Welsh Government guidance issued, with phased implementation of the action across financial year 2023/24
	To review findings of local Peer Review and data analysis to inform SDEC model 2023/24	Matthews, Rhian	30/09/2023	Model to be developed
	To review findings of GP Out Of Hours Peer Review, and implement actions as part of planning objective 3A	Matthews, Rhian	30/09/2023	Work is underway
	To develop a plan with Local Authority partners that sets out a model for integrated community health and care provision for older adults and adults living with frailty	Matthews, Rhian	30/11/2023	Work is underway across the three counties.

Appendix 2

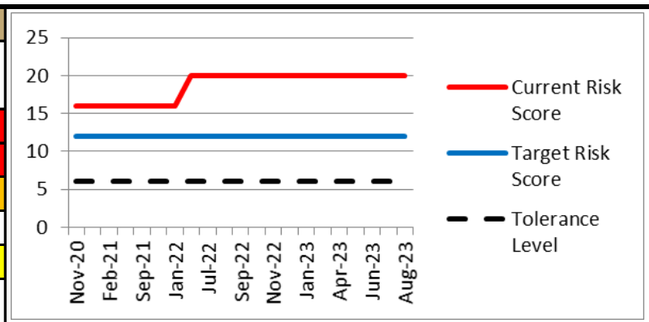
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance indicators. A suite of unscheduled care metrics have been developed to measure the system performance.	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd								
	Bi-annual reports to SDOPC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDOPC & Board	2nd								
	WAST IA Report Handover of Care	3rd								
	11 x Delivery Unit Reviews into Unscheduled Care	3rd								
	Delivery Unit Report on Complex Discharge	3rd								

Appendix 2

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Aug-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Sep-23

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk to the delivery of timely diagnosis and appropriate treatment to those on the ASD waiting lists, and the commencement of interventions for Psychological Therapies within required timescales. This is caused by an increase in referrals and increasing DNA rates (c25%), as well as recruitment challenges for psychologists. This could lead to an impact/affect on those currently awaiting diagnosis and intervention, resulting in delays in care and appropriate treatments in a timely manner which may lead to poorer patient outcomes, and delayed adjustments to educational needs. There will also be an impact on the ability of the Health Board to meet Welsh Government targets (diagnosis of ASD within 26 weeks, and commencement of interventions for Psychological Therapies within 26 weeks) which could lead to increased scrutiny from regulators, and escalation from Welsh Government. This in turn could result in adverse publicity and a reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			138, 1249, 1286, 1287, 1392, 1455, 1422, 1524, 1290, 1260

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The service was experiencing significant waiting times as a result of increasing demand levels which are now back to pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates (c25%), ongoing recruitment challenges and increasing demand there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. For psychological services a trajectory is now in place for 1% per month.

Rationale for TARGET Risk Score:
The Directorate is prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined. The target risk score will be dependent on securing recurring funding for the IAS as well as having access to appropriate clinical venues and other agencies being able to undertaken their associated assessments. While trajectory plans are in place as of March 2023, there is recognition that the Health Board will not achieve WG targets.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as AttendAnywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional funding provided for recruitment however national shortage of required skills - 3 new staff have been recruited into the ASD team. Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. Regular meetings with Women and Children's Service to strengthen interdepartmental working. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation. Papers have been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures. Service Delivery Manager appointed and in place. Continual review of vacancies via MHLD QSE meetings resulting in the consideration of alternative staffing models when recruitment drives do not materialise. Workforce Redesign Group has been established. Trajectories have been identified for Memory Assessment Services and S-CAMHS and there are systems in place to monitor waiting lists at service	Continued lack of IT impacts on staff who have to work from home not having full accessibility. Estates issues ongoing with no access to clinical areas in some localities to see CYP and unable to access GP or LA sites thus restricting clinical sessions. Telephone assessments ongoing, virtual assessment offered but uptake not good for ASD and SCAMHS client group. Reliant on locally held data until reporting available via WPAS team. Currently with Software Development Team since go-live in April 2022.	Directorate is working with the Health Board Performance Team to provide a more detailed report as to the current actions being taken by the Directorate.	Carroll, Mrs Liz	Completed	This work is aligned to the migration of services to WPAS on a priority basis, and complete as at March 2023.
		Explore opportunities for outsourcing for CAMHS ASD and Psychological Therapies.	Carroll, Mrs Liz	Completed	Action included on service level risk register.
		Keeping in touch processes to be in place (Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	Completed	Psychology In May 2023, 52 (40.00%) patients out of 130 were waiting less than 26 weeks to start psychological therapy in the Learning Disabilities Psychology Service. 78 (60%) were waiting more than 26 weeks. This is a month on month improvement since January 2023 and the position is likely to further improve due to Psychologists returning from maternity leave and recruitment. All new referrals are screened by the Community Teams and priority given where possible. Waiting lists review has been undertaken and keeping in touch letters in easy read have been sent out to all on the waiting list. We have recruited 8b psychologist who commences in August 2023. OT Urgent referrals taking priority. • Continue to prioritise referrals and support workforce modelling as part of service improvement work

level, through IPAR and Directorate performance meetings. Regular meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Within the service there is progress in terms of identifying clinical space due to the challenges experienced in accessing additional accommodation outside of the Directorate. Linking with wider Health Board, including corporate teams/Local Authority use of hubs. Works completed in Bro Cerwyn and staff have now returned. Units within the MH&LD footprint have been repurposed. IT are updating infrastructure to enable most efficient use of available space. Service Leads have been tasked with identifying alternative estate options for their areas. Work underway across all services who have waiting times, be they intervention or assessment. Use of HB Third Party Contractor has begun and initial letters sent to those waiting appointments with the Memory Assessment Service, Integrated Autism Service and Adult ADHD. Public facing webpages with QR codes are also being developed to give further guidance and support whilst individuals are waiting. Template letters being developed within further areas. Monitoring of this process will be the responsibility of individual service leads. Service Leads are exploring opportunities for outsourcing for CAMHS ASD and Psychological Therapies. Commissioned external provider for ASD services across all ages, similar contract out to tender for Psychological Therapies. 'Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme.					underway. • Additional up-skilling B4 techs • Reviewing universal offers of support/workshops for families and carers particularly around sensory processing referrals. • Reviewing use of caseload weighting tools and enhanced professional lead oversight of caseloads • Limited clinical support from AMH B7 in Pembs CTLD. • Additional 1.0WTE B6 OT post to cover Carmarthenshire, and 1.0WTE OT B6 post within WEIT being proposed as part of SIP. Physio LD Service Manager EOC will attend peer meetings in the absence of a professional lead. EOC has advised the Physiotherapist that she will be validating and monitoring the waiting list reporting to the Information Dept on a monthly basis until they have a Prof Lead in place. Services developing a professional lead physio for LD JD. All LD Therapies Service Manager EOC has advised the to adopt Psychology's approach of formally writing to each individual on the WL over 6/12 as part of the regular Waiting list review cycles.
Repurposing current MH&LD Estate in line with clinical priorities identified.	Carroll, Mrs Liz	Completed	Operational Planning and Delivery Programme Meeting on the 03/05/2023 where it was agreed that the Tudor House Estate would revert back to the Directorate.		

Identify alternative venues/space to hold clinics(CAMHS & Psychological therapies).	Lodwick, Angela	~~31/03/2023~~ 30/09/2023	Challenges continue in access to Estates to undertake assessments across the three counties. Remains ongoing working with Estates and submitting capital bids to WG for monies to fund works within allocated buildings to make them fit for purpose. SBAR being developed to repurpose the use of Tudor House.
Identify alternative venues/space to hold clinics (Integrated Psychological Services).	Marshall, Selina	~~31/07/2023~~ 31/07/2023	Rolling programme of groups being developed to enable additional clinical capacity within the service.
Identify alternative venues/space to hold clinics(Commissioning /CDAT).	Richards, Matthew	~~31/03/2023~~ 30/09/2023	New North Dock premises are being progressed by APB to deliver new base in Llanelli with accessible clinic space. Currently going through planning and concerns about potential delays due to public objections
Directorate to transfer all service data collection processes to WPAS.	Amner, Karen	~~31/03/2023~~ 30/03/2024	Delays to the Dementia Wellbeing Service, Integrated Autism Service, Perinatal, Memory Assessment Service migration delayed due to capacity within the Digital team to test and develop system at required pace.
Request to be made for additional IT kit to support agile working.	Carroll, Mrs Liz	Completed	Request submitted 23.10.21.
Directorate has funded 12 month fixed term post to accelerate the transition of the entire Directorate on to WPAS with a view to this improving waiting list management and demand and capacity planning. A further two posts have been funded within the Informatics service.	Amner, Karen	Completed	Mapping work continuing MAS, Admiral Nursing, DWBT and Perinatal. Data migration of Integrated Psychological Therapies spreadsheets completed 10.4.22 and service now inputting data at source. for IAS service with the new Service Delivery Manager has now gone live on the 1/11/22 Training sessions continue to be available.
Identify alternative venues/space to hold clinics.	Carroll, Mrs Liz	Completed	These actions have become control measures.

Services will be in contact with individuals to provide information regarding community support, well being at home and guidance should their situation deteriorate.	Carroll, Mrs Liz	Completed	Action assigned to individual service leads.
Funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development has been identified fixed term for 12 months and will work in conjunction with the new ASD Service Delivery Manager (in post 6 March) to address waiting lists.	Carroll, Mrs Liz	Completed	Interim Clinical Psychologist due to take up post by end of July 2022.
To complete an impact assessment on the recommendations of the Autism Code of Practice.	vaughan, Catherine	Completed	The Regional Partnership Board have commissioned Alder Advice to undertake an audit of our compliance (Health Board/Local Authority/Stakeholders) against the recommendations outlined in the code of practice. We have submitted our developments to date. A regional action plan will be developed based on the outcome of this audit. Implementation plan has been received which members of the Regional Strategy Group are considering. Mapping exercise being undertaken with regard to training needs. Understanding Autism training being rolled out across the Health Board with more specific training for clinicians within the MH&LD Directorate being commissioned.
Review workforce skill mix in light of any potential new funding received from WG for Neurodevelopmental services.	vaughan, Catherine	31/03/2024	Workforce reviewed and skill mix within team expanded to ensure a multidisciplinary approach in order to deliver an integrated multi disciplinary service in respect of the fixed term funding for 2023/24 received on behalf of the Regional Partnership board(RPB).

		Monitor the use of SIFT monies for service development. The Director of Finance has given an undertaking that this will be funded as discussed and agreed at a Directorate Improving Together Session in April.	Carroll, Mrs Liz	31/03/2024	During the budget setting process in Month 7, the £575k for procurement for EMDR and ASD was not factored into the Directorate position despite this having been agreed following agreement at Public Board in September 2022. This was raised by the Finance Business Partner during the budget setting process with Finance colleagues. This leaves a deficit in this years budget.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22)	System to improve analysis of patient experience	Outcome measures to be in place to measure effectiveness/quality of services provided (CAMHS & Psychological therapies).	Lodwick, Angela	~~31/03/2023~~ 30/09/2023	S-CAMHS is implementing nationally agreed Welsh Government Outcome Measures - staff have received training as part of the Welsh Government Initiative. Gold Based Outcomes, SDQ and YP Core. Remains ongoing.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd					Outcome measures to be in place to measure effectiveness/quality of services provided (Older Adult Mental Health Services).	Mason, Neil.	~~31/03/2023~~ 31/10/2023	Information reported through Head of Service report to QS&EG. Patient experience feedback process in development in collaboration with corporate team. Admiral Nurse Service is fully compliant. All CMHTs have agreed a standard-set of outcome measures CROMS/PROMS/PREMS for both People Living with Dementia & service users with functional mental ill health problems and their carers, commencing application. MAS have nearly completed. OAMH hosted a Regional Lead post to facilitate directorate wide improvements for PROMS.

	MH&LD QSE Group overseeing patient outcomes	2nd						Outcome measures to be in place to measure effectiveness/quality of services provided(Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	Completed	Due to staffing issues it has been difficult for the Business Manager to take further with the SALT team due to pressures within services. Business Manager is liaising with Sarah Mackintosh from Carmarthenshire People First with questions to go onto an easy read format. Meeting with Carmarthenshire People first on 17th April 2023 to go through the questions for the easy read format. Once easy read format has been completed Business Manager will take to Q&S Team to add a QR Code to give the service user the choice of both options. 15/06/2023 both easy read and electronic forms completed, meeting with CTLD managers taking place to roll out the new forms.
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd						Outcome measures to be in place to measure effectiveness/quality of services provided(Commissioning /CDAT).	Richards, Matthew	~~31/03/2023~~ 30/09/2023	CDAT outcomes measures are gathered using TOP assessment for all service users and reported via quarterly KPI's to APB and WG. Commissioning outcomes measures are being reviewed and recent work with NCCU will support this. Possibly pilot an outcome framework with NCCU as a temaplate for national approach.
	W-PAS Internal Audit (reasonable assurance(	3rd						There are outcome measure in place within Psychological Therapies following intervention with a plan to develop a Task and Finish group to look at themes and areas which may require further improvement.	Marshall, Selina	Completed	Directorate have been asked to participate in Health Board wide Task & Finish group. The Directorate will raise the importance of Service User/Carer input into this group to ensure the patient experience is represented to inform the outcome. Outcome measures will form part of this project.
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.										

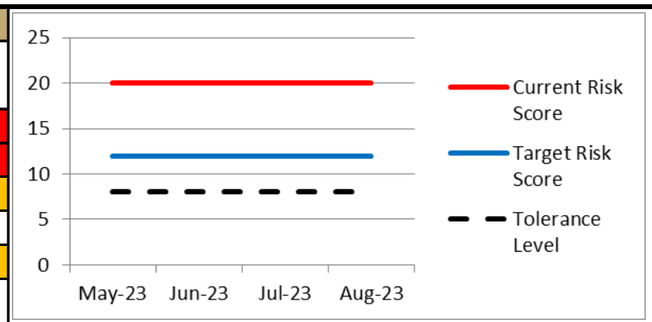
Appendix 2

Date Risk Identified:	Nov-19		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

Risk ID:	**797**	**Principal Risk Description:**	There is a risk of being unable to provide a full range of ultrasound services including antenatal. This is caused by the retirement and resignation of current sonography staff, low availability of sonographers UK wide, including locum staff and the inability to recruit to due national shortages of qualified staff, and the inability release existing workforce to train and develop to meet current service demands. This could lead to an impact/affect on delays in diagnosis which could result in detrimental outcomes for patients, inability to meet diagnostic targets and cancer pathway targets, and an inability to hold clinics to meet demand in ante natal screening services within required timescales. In addition, there is an impact on staff health and wellbeing in terms of the volume of patients examined within a shift/overtime, which could lead to increased incidents of repetitive strain injuries (RSI), along with increased incidents of staff stress and burnout. This could ultimately lead to increased errors when performing the dynamic diagnostic test.
Does this risk link to any Directorate (operational) risks?		1557, 1349, 1658	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	8
Trend:	*New risk*



Rationale for CURRENT Risk Score:
Despite best efforts, the service remains fragile and supported by long term agency staff. Vacancies remain unfilled, with the inability to recruit despite repeated recruitment attempts. Long term vacancies exist in Bronglais, Prince Philip and Withybush - in particular in terms of modality lead sonographers at Withybush as at July 2023 - it is noted that a secondment is currently underway at PPH. There are a number of expected retirements and planned maternity absences in the near future. There will also be the inability to secure agency staff from July 2023 in Withybush. As a result of the loss of ultrasound modality leadership in the team at Withybush, this is resulting in reduced ability to undertake governance and audit requirements. A midwife has recently qualified after receiving sonography training at Withybush in April 2023, and a further trainee qualified at Prince Philip, but has since gone on maternity leave. More sonographers are due to be trained from January 2024. However, difficulties remain in obtaining locum staff, exacerbated by registration requirements. As at July 2023, the Radiology directorate have four adverts for differing sonography roles across the Health Board, ranging from leadership in sonography and training, with vacancies open until September 2023.

Rationale for TARGET Risk Score:
The actions below will not in themselves reduce this risk significantly. Support is required to undertake the demand and capacity and the current establishment reviews. It is likely that these reviews will lead to a need for further investment and additional funding to establish a sustainable service model to include a robust perpetual training programme, that will enable the Health Board to met expected diagnostic waiting times targets.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Process in place for the movement of staff across the Health Board to maintain capacity. Additional sessions held where possible by a small cohort of non-injured substantive staff to increase obstetric capacity. Urgent escalation at WGH is currently covered by site lead, however this is not sustainable. Ultrasound Control Group now in place, meeting on a fortnightly basis to assess current sonography position across the Health Board, and to develop a short-term and medium-term strategy, both temporary and permanent to encompass and look at current models and staff skill set. Meetings are attended by colleagues from Women and Children, Head of Strategic Workforce Planning, AD of Therapies, Director of Public Health, GM for Radiology, Head of Radiology and site leads.	No long-term modality lead in WGH. The PPH modality lead has left however will be a secondment filled for a 6 month period. Inability to release existing staff to train and develop to undertake sonography and growth scans. Inability to recruit and retain staff. Lack of suitable accommodation to attract new staff.	Develop a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Lingwood, Gill	~~31/12/2022~~ 31/10/2023	Discussions have taken place with Head of Maternity Services. Protocols and training being developed. Implementation date to be agreed. Meeting scheduled for 20th June 2023 with CVUHB in order to assist with the development of a training plan
		Train members of staff to become sonographers, the number of which dependant on capacity to take training.	Roberts-Davies, Gail	~~31/03/2020~~ ~~31/12/2022~~ ~~01/02/2023~~ ~~30/09/2024~~ 31/01/2026	As at June 2023, it is hoped that 4 members of staff can be trained - however this is dependant on the desire of current to undertake the training, and the ability to recruit to training positions. Training positions take two years to complete, with a view to these commencing in January 2024. Clinical Educator roles have been developed, with job descriptions being presented to panel in June 2023, after which the Directorate will be able to advertise these vacancies, and if successfully recruited to, will allow for additional training to be undertaken.
		Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	31/10/2023	Fortnightly workforce planning meetings in place with colleagues from Radiology and Workforce in attendance.

Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Jones, Keith	~~30/06/2022~~ ~~30/11/2022~~ ~~31/03/2023~~ 30/08/2023	Initial contact made with workforce planning team re: establishment review work, and this work is also being supported by the Value Based Health Care team as of November 2022. This has been discussed in the Radiology Use of Resources Meeting and further discussions are taking place in regard to establishing a Radiology Planning and Delivery Group to bring together all pieces of work with the necessary expertise. It is noted that this group has yet to be established as of April 2023, however a focussed Ultrasound Control Group has been set up, recognising the imminent loss of service. Radiology dashboard is now in place and functional.
Explore opportunities of recruitment/training of physiotherapists, midwives and other Allied Health Professionals to undertake ultrasound examinations	Roberts-Davies, Gail	Completed	Opportunities are discussed via the Ultrasound Control group which commenced 21st April 2023. These options have been offered to relevant staff, who have the opportunity to apply. Once clinical educators are in post, any internal vacancies which remain will be advertised externally as training posts for Allied Health professionals.
Explore opportunity to creating and recruiting clinical sonography educators post for the Health Board	Lingwood, Gill	31/10/2023	Clinical Educator roles have been developed, with job descriptions being presented to panel in June 2023, with the role being advertised in July 2023. Once clinical educators are in post, any internal vacancies which remain will be advertised externally as training posts for Allied Health professionals.
Explore incentivisation options in terms of being recruit and retain substantive sonographers	Roberts-Davies, Gail	30/09/2023	Ongoing, and consideration to be given in terms of enhanced advertising to include relocation expenses.
To review accommodation options to support the recruitment of locum sonographers.	Roberts-Davies, Gail	30/09/2023	Head of Radiology to meet with Head of Strategic Workforce, Planning and Transformation on 16 June 2023 to explore this option further

Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - currently >over 40 weeks Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Bronze and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (24% of USC carried out in 7 days, 41% carried out in 14 days at March 2023), included in the IPAR & reported to WG	1st								
	Performance monitored at Directorate Improving Together Sessions	2nd								
	Performance monitored via IPAR, overseen SDODC & Board	2nd								

Appendix 2

Date Risk Identified:	May-23	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jul-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

Risk ID:	**1664**	**Principal Risk Description:**	There is a risk to service sustainability in Ophthalmology across the Health Board, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration (wAMD), Diabetic Retinopathy (DR) and Cataracts. The service currently has 5210 patients that have been 100% delayed for their follow up appointment. The total New patient referrals is at 6186 of which 1081 are breaching 52 weeks (the longest wait from this cohort is 95 weeks). 3759 patients are awaiting an Ophthalmic operation of which 128 are breaching 104 weeks (the longest wait from this cohort is 220 weeks). This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies. The workforce position is exacerbated by nursing and medical staffing constraints and a reduction in service capacity due to lack of physical space, and long-term funding. Recruitment difficulties are leading to the Consultant on-call rota being covered by three substantive Consultants and a high cost Locum Consultant (Medacs) to ensure the delivery of the Ophthalmology service. This is a fragile on call structure which is impacted by sickness and AL. This could lead to an impact/affect on the Health Board's ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and delays in the NICE guidance 14-day pathway for AMD appointments, impacting on the ability to provide timely diagnosis and treatment and directly impacting on patient safety with the potential for sight loss and long-term lifestyle impacts. This will also affect the Health Board's ability to comply with Welsh Government Eye Care Measures (ECMs), and service pressures are impeding on the Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates. This in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government. Workforce pressures could also impact staff well-being and morale.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	5×5=25	
Current Risk Score (L x I):	4×5=20	
Target Risk Score (L x I):	2×5=10	
Tolerable Risk:	6	
Trend:	*New risk*	

Appendix 2

Rationale for CURRENT Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board. Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet AMD was incorporated into IMTP but no funding was allocated. The current Impact has been scored as 5 because patients suffering irreversible sight loss or damage is a reality and the current Likelihood has been scored 5 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without a regionally agreed solution.

Rationale for TARGET Risk Score:
It is unlikely that the service will be able to reduce the impact score of this risk as the consequences to the patient remains high, however due to recent re-structuring of the management team within Ophthalmology it is hoped that this will provide opportunities to review and improve service delivery with an initial focus on meeting eye care measure targets for the most high risk cohort of patients. The recent addition of a substantive WTE Consultant will help to address the longest waits. A Regional Consultant post has been recruited in Swansea bay to provide an additional 10 sessions a week in HDUHB. With the above additional workforce and focused management of the waiting lists, HDUHB will potentially help to reduce the likelihood score on this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Active recruitment to vacancies, x1 substantive Consultant has recently been appointed. The ambition is for x1 substantive Consultant post to go out to advert as a Regional post. Regional Business Case for a South West Wales Glaucoma Service. Regional discussions regarding a South West Wales Consultant On-call provision. Additional weekend working to provide Wet Age related Macular Degeneration (AMD) capacity. Currently funded for x2 all day lists per month. Lists cancelled due to AL are offered out to backfill. Review of service rota recently undertaken by Clinical lead to ensure stability to existing team and robust cover of emergency work. Identification of patients suitable to undergo Community Glaucoma data capture and virtual review by Consultant Ophthalmologists.	Whilst recurring money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop to consider opportunities for a long-term regional model are needed. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding was in place until March 2023. Transformational funding from Welsh Government is in place until March	Regional discussions to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services.	Coppack, Victoria	30/09/2023	To be updated with more details once plans for discussions are in place
		Root and branch review of operational, workforce and sustainability models .	Coppack, Victoria	~~30/06/2001~~ ~~31/03/2022~~ ~~31/10/2022~~ 31/12/2023	Root and branch review to be undertaken through ARCH group. Regular meetings need to be undertaken for Glaucoma and Workforce plan.
		Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~07/06/2021~~ ~~31/10/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ 31/10/2023	Issues identified in the planning phase around data governance. National team; are working to resolve issues and will provide an update in October 2023. The launch of EPR could be as far as 2025.

Full Business Case for OpenEyes software (National Electronic Patient Record for Ophthalmology) approved and dedicated Project Manager has been appointed to oversee implementation. ARCH Glaucoma workstreams in place. Validation taking place through scheduled care validation team. Clinical validation of all HCQ patients to be undertaken by nurses. Additional weekend clinics in place for AMD patients. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. ECM Coordinators in place. 7 prescribing hubs have now been set up across the Health Board, with the aim to reduce the number of patients requiring secondary care Eye Services, ensuring those with the need for secondary care intervention are referred. Highly trained Optometrists working collaboratively with the secondary care Eye Service to reduce referrals to secondary care. Continued training of Optometrists within secondary care to continue to develop this service. ARCH workstreams in place- looking at Glaucoma and funding has been secured to support this development. ARCH support around Diabetic retinopathy and cataracts has been completed and pathways are in place. Ongoing arrangement of Optometrists enrolling in prescribing training.	2024. Actions have assisted the backlog number of patients waiting to be managed in subspecialties such a Diabetic Retinopathy however other high volume areas such as AMD and Cataracts continue to see growth in waiting times. There are concerns in data quality due to referral processes and system use. The Ophthalmology service has continued to recruit over budget to sustain current services.		

Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.	Coppack, Victoria	~~31/01/2022~~ ~~31/03/2022~~ ~~30/04/2022~~ ~~30/09/2022~~ 31/10/2023	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) has been completed since March 2022. Recruitment into nurses posts to support out-patient activity has delayed move to out-patient area. Scoping project to be undertaken to look at undertaken Consultant led eye implants/complex patients through this out-patient space.
Plan for Glaucoma pathways to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ 31/10/2023	Business case has been approved and pathway has been implemented with support from Swansea Bay Consultant. ODCT pathway x1 has been developed, funding for second ODCT pathway secured.
Recruitment of approx. 7 nursing staff and 2 technicians.	Barreiro, Marta	~~30/06/2022~~ 31/10/2023	2.0 WTE Technicians secured 0.8 WTE Glaucoma practitioner secured. 3.3 WTE Nurses secured Outstanding 1.9 WTE Glaucoma practitioner and 1.0 WTE Nurse which have not been recruited into.
Recruitment drive for Glaucoma Consultant.	Barreiro, Marta	~~30/09/2022~~ 30/09/2023	x2 Consultants secured through Swansea Bay. X1 WTE equivalent to work in HDUHB. Job planning currently being agreed.
Remodelling the capacity and demand associated with Wet AMD and Amman Valley (Action transferred from Closed Risk 180 and Risk 632)	Coppack, Victoria	~~31/03/2023~~ 31/10/2023	Ongoing costs associated with additional activity. Pathway review to be undertaken once establish demand and capacity planning for this sub-specialty has been undertaken.
Recruitment of theatre staff and admin support to enable the optimisation of AVH theatres for cataracts.	Barreiro, Marta	~~31/03/2022~~ ~~30/08/2022~~ 31/10/2023	Inability to recruit additional theatre staff has prevented the increase from 2 days a week theatre. To be reviewed with theatre Sister to develop action plan.

Devise and approve plan for Diabetic retinopathy service through ARCH.	Barreiro, Marta	~~30/06/2022~~ 07/09/2023	Funding was secured through transformational bid. Carmarthenshire and Pembrokeshire have secured timeliness of patient appointments for follow up and new patients. Ceredigion has been more challenging due to lack of Optomotrist uptake. Aberaeron integrated care centre has now been secured for x1 session per week supported by a technician.
Plan for Cataracts pathway to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ 30/09/2023	Locum Consultant secured to assist with delivery of Cataracts surgery/Substantive Consultant with specialism in plastics secured who can also undertake cataract surgery. Review of Demand and Capacity to be undertaken to scope out service recovery.
Implement virtual review clinics for patients undergoing HCQ treatment.	Coppack, Victoria	~~30/09/2022~~ 31/10/2023	Validation of HCQ patient being scoped. Longest wait HCQ patients have been identified. Virtual review process to be discussed with Clinical lead. Clinic spaces to be secured for patient review. This is an interim measure whilst community hub is being developed.
Clinical validation rota to be established within the service to ensure validation of high risk patients and longest waits is undertaken to prioritise patient reviews and safety net patients	Coppack, Victoria	30/09/2023	To be updated next review
An SBAR to be prepared around fragility of ophthalmology service, inclusive of concerns around data quality.	Coppack, Victoria	31/08/2023	To be updated next review
A sustainable model for AMD to be developed with continued support from performance team.	Coppack, Victoria	31/10/2023	To be updated next review
Weekly monitoring of each sites AMD demand and capacity to allow for recovery planning of breaching patient waiting times.	Coppack, Victoria	30/09/2023	Robust Demand and Capacity plans to be developed for each sub-specialty and allocation of resources to protect high risk patients within Ophthalmology

Appendix 2

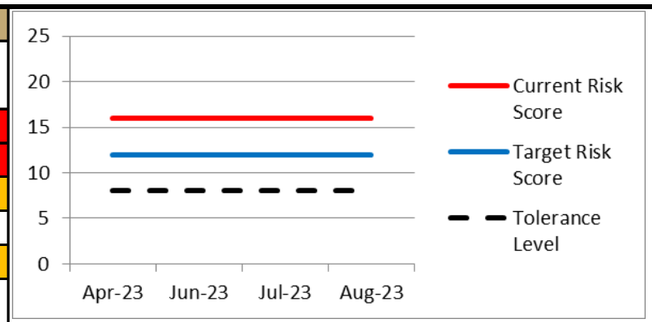
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report.	WPAS	1st								
GIRFT review Cataracts.	GIRFT action plan cataracts	1st								
GIRFT review Glaucoma.	GIRFT action plan Glaucoma	1st								
Watchtower review of ministerial measures	WPAS, scheduled care performance indicators	1st								

Date Risk Identified:	Apr-23
Strategic Objective:	

Executive Director Owner:	Gostling, Lisa	**Date of Review:**	Jun-23
Lead Committee:	People, Organisational Development and Culture Committee	**Date of Next Review:**	Jul-23

Risk ID:	**1649**	**Principal Risk Description:**	There is a risk there will be insufficient skilled workforce available to meet our Ministerial Priorities across all areas (UEC, Planned Care, Cancer and Mental Health etc). This is caused by the scarce supply of healthcare professionals and a shrinking labour market, which is further exacerbated by the Health Board's current vacancy rates. This could lead to an impact/affect on the quality of care provided to patients, delays in care and poorer patient outcomes and experience. In addition, this may lead to the inability to meet statutory and professional requirements in terms of safe staffing levels that are needed to deliver quality patient care. And further impact on the health and wellbeing of teams.
Does this risk link to any Directorate (operational) risks?		205, 86, 820, 232, 1298, 1281, 906, 90, 632, 525, 1223, 1083, 111, 114, 199, 523, 1238, 200, 180, 1245, 1224, 1309, 1152, 1211, 105, 119, 118, 1305, 1295, 1377, 842, 138, 153, 156, 939, 940, 1409, 1419, 628, 1316, 1317, 340, 1301, 1663, 1460	

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	8
Trend:	⟺



Rationale for CURRENT Risk Score:

This risk has been scored as 16 (the likelihood is "likely" and has the potential to have a "major" impact) as the number of staff impacted from staff sickness is still high at Apr23 compared to pre-Covid levels (c2-3% higher) however, there has been a general improvement over the last 12 months. Staffing levels (acute & community) continue to operate below established levels due to both vacancies and sickness/absence, and use of bank and agency. There is still a significant risk of workforce misalignment with activity and required competence levels. Further work has been undertaken to understand the level of risk across each staff group, speciality and site to fully comprehend the level of risk the organisation carries as a whole. It is hoped as further action is taken through stabilisation, Improving Together and workforce planning to reduce the risk score during 2023/24.

Rationale for TARGET Risk Score:

The Target Risk score indicates the likelihood of the risk occurring (absence target 4.8%). Other intelligence leads as to be alert to workforce issues as evidence suggests that patient acuity is increasing and therefore workforce requirements will increase by proxy until new models/methods to reduce or manage complexity can be identified. Also, it may be that there could be concerns for the specific services and/or the annual risk of a winter surge developing when at full capacity for recovery/ministerial priorities as we have a "finite" resource in our people that can only be stretched so far without causing detriment. Therefore, the probability sits between 75-90% when taking account of multiple factors - respiratory infections, increased patient acuity, the longer term impacts of COVID-19 on the population i.e. inability to access services needed, and workforce resilience. We hope we will be able to take mitigated actions noted below predominantly through our interventions under the Regeneration Framework in the short term and for the medium to long term begin to realign available workforce to new service design and models of care. This risk is wider than a 12 month period as actions taken or not taken today will have a long term legacy on our available future workforce and capacity/capability to manage the associated challenges of service & workforce redesign (linked to Principal Risks 1186 and 1188).

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Organisational Governance Structure People, Organisational Development and Culture Committee (PODCC) Strategic People Planning and Education Group (SPPEG) & underpinning Governance Structure for People Planning & Education to create an organisation wide assessment for our 10 year strategy Improving Together approach to be align to People Planning approach supported by People Planning Team to create an organisational wide approach to in year service challenges Organisational Gap Analysis based on a 10 year profile developed and annual assessment strategic & operational review of workforce (including Education Commissioning Assessment) Inter-People and Corporate Team & Planning Objectives Establishment Control Agency usage Bank Utilisation & ongoing onboarding of supply Efficient Rostering practice Roll out of new rostering system Overview of organisation and service wide risks (assessment of each service area based on workforce availability) Continuous process of assessment of services to be stood down and deployment options based on service needs (ODPD) Targeted prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery (People & OD Strategic Group) Temporary People Utilisation reports shared regularly to monitor levels of supply	Workforce planning groups need time to mature and develop focus underpinning SPPEG Capacity and capability in people planning within team and across organisation required Establishment control cannot be relied on as one source of truth for information as a) partially due to temporary changes linked with pathways, b) 9 sources of information not all feed into the establishment control tool and c) data management issues in ESR, eg, single employer status for our medical workforce. Tools to enable modelling in short, medium and long term to enable alignment of population health, labour market, internal labour market, activity & performance analysis aligned to financial constraints (work arounds utilised but gaps/issues exist). Critical analysis of people alignment to priorities for delivery within financial considerations for short, medium & long term. A robust framework of competency based people planning and related training to underpin the Team around the Patient initiatives and new model development of care.	Development of All Professions led people plans to align to in year tactical & operational plans linked to the overarching Strategic 10 year Workforce Plan. (See carried forward action below)	Walmsley, Tracy	31/03/2023	Improving Together alignment to overarching professional groups to create alignment to in year tactical & operational issues; to be summarised and fed into Strategic People Planning & Education Group for quarterly monitoring. Summary of status of all professional groups in place via the development of the Workforce Technical Document. Stabilisation programme supporting specific services/sites - alignment required to 3-10 year strategy via development of People Road Map (Linked to People Planning Objectives 2c - Overarching workforce, od and partnership workforce plan) 1-3 year workforce plans in place testing "robustness" through assessment of risk and service change proposals.
		Analysis of all service levels workforce & od risks within 1-3 year timeline, and where appropriate to 10 year timeline. (PO2c2.i)	Walmsley, Tracy	30/06/2023	Paper summarising all W&OD risks will be issued to SPPEG & PODCC for review and assessment of agreed prioritisation of actions. These have been reviewed in context of 1649 aligned risks, the wider themed risk register for workforce and DITS papers (32 risks identified and linked; a further 88 risks being assessed and profiled against WOD pillars for assurance against proposed actions & mitigations. Paper to be ready by mid July) NB relationship to demand & capacity noted as a risk based on review of DITS actions against services.
		PO 2a: Develop Career Progression Opportunities for all that want them aligned to the overarching workforce plan & strategy (ensuring underpinning methods and processes support this activity i.e. education commissioning)	Glanville, Amanda	~~30/07/2023~~ 31/03/2024	On track

Completion of Education Commissioning Plan to HEIW and critical assessment to known service level plans as at March 2023 submission to Welsh Government (PO2c2ii)	Walmsley, Tracy	~~09/05/2023~~ 30/09/2023	Education & Commissioning response for 2023 shared in Mar23 with HEIW. Queries & gaps raised by People Planning Colleagues and HEIW. Follow up actions in place. Ongoing plan & specifics based on a critical analysis of IMTP by professional leads and service plans over a 5 year time frame. 2023/24 Education Commissioning Template for 2026/27 outturn will be completed and updated as requested by HEIW by 26 Apr23. Ongoing dialogue between service/education leads/HEIW in place. (Linked to People Planning Objectives 1b, 2c.) Critical issues paper to be developed from submission and discussion for meeting with HEIW on 20th June 2023 to include Psychology, Radiology (Sonography - Ultrasound), Pathology, Ophthalmology etc. Agreed to hold workshop at HEIW on receipt of "critical issues" paper.
Further develop training resources and capacity to support managers with workforce planning challenges to alleviate risks (PO 2c2iii)	Walmsley, Tracy	~~31/07/2023~~ 30/09/2023	Initial training programme drafted; dates in diary Jul to Sep23. Linking with Risk Team to ensure aligned process including awareness raising and support. Bespoke programmes being developed for specific services such as Pathology
Approach to future community workforce development model requires alignment to UEC, Primary Care and Community Programmes of work & teams. (PO2c.2v)	Walmsley, Tracy	31/07/2023	Baselines in place; design methodology required and bought into by group. Progress: stalled due to "definition" of community and underpinning frameworks. May be other opportunities to reflect on work linking to social model approaches. Requires an assessment of approach and capacity to move forward. Work with leads to define "what and how", and explore opportunities to link to the Clinical Services Plan.

Analysis, design and development of the infrastructure and governance to develop the a new model of care i.e. OBC and Social Model of Health i.e. resource requirements, alignment to current structure and service design programmes (workforce planning for workforce, planning/project management, communications & engagement, clinical oversight).	Williams, Paul	30/09/2023	Resource identification has been reviewed and a phased plan of implementation agreed by Executive Team. Requires alignment of new resources within current operating model/infrastructure to make best use of resource and manage risks. Progress: no further update on specific as Clinical Review with WG in progress and will be complete by Aug23. A re-assessment will be needed aligned to work that will start within the "pathways" and PMO/TPO. Consideration of governance mechanisms to support alleviation of strategic workforce risks (7-10 years)
Digital support with workforce planning to support speed in decision making at local, regional & national levels. (Regeneration Framework adopted as a national model). Interdependent need to link population health, external labour market analysis, demand & capacity and activity modelling, internal labour market analysis to pathway design, patient outcomes and staffing models based on appropriate assumptions, scenario planning and financial models. (objective 2c c link " quantitative and qualitative workforce intelligence"). (PO2c3i)	Walmsley, Tracy	30/09/2023	HEIW developing National Observatory in 2023/24. Data Design & Solution Project Manager in post. Exploring approach to workforce data linked to People Planning Objective 2c and Improving Together and BAF work.
Agree actions to mitigate strategic risks of workforce supply based on assessment paper	Gostling, Lisa	31/03/2024	Risk assessment in progress
Test "WFP" Project Support Role within a Directorate to strengthen operational and strategic workforce planning: Women & Children	Walmsley, Tracy	30/11/2023	Meeting with LH held to test aligned to Improving Together action identified. Initial introduction planned June 2023 for a 6 month trial period.
Methodology to support new and enhanced roles scoped and implemented.	Walmsley, Tracy	30/07/2023	Linked to Pepople Planning objectives 23/24 - plan on a page in development. Alignment of learning to date from role design, team around the patient, quality improvement and value based healthcare to be assessment.
Interrogate financial establishment/SIP to ensure "a source of truth" and align to identified and prioritised risks (operational and strategic).	Walmsley, Tracy	31/03/2024	Meeting to review risk to be set up to link in "Stabilisation" and wider Establishment Concerns (links to Principal Risk 1186)

1a Develop an attraction and recruitment plan (which enables service sustainability) and deliver a plan which is designed to streamline and modernise processes, recruitment from different talent pools, attract and support candidates	Gostling, Lisa	31/03/2024	On track
1a.1 Redesign all JD & PS to focus on core requirements and skills	James, Michelle	30/06/2023	Schedule developed; next steps to be implemented.
1a.2 Employ new methods of advertising and appointing to roles	James, Michelle	30/06/2023	Schedule developed; next steps to be implemented.
1a.3 Develop programmes for employability support	James, Michelle	28/02/2024	Partners engaged, 3 programmes identified and being scoped fully.
1a.4 Develop attraction plan to link with offers for R&D, Service Improvement, Education etc	James, Michelle	30/09/2023	Tender action completed - work ongoing - revised timelines of plan to be developed
1a.5a Appoint to vacancies via different employment pools (resourcing)	James, Michelle	31/03/2024	Scoping for AHP & Medical roles (first action by 31 July) in progress. Various actions ongoing to March 2024
1a.5b Appoint to vacancies via different employment pools (learning & development)	James, Michelle	31/03/2024	In progress, including scoping of medical apprenticeships
1a.6 Enhance HB offer to improve lives of local population by social responsibility initiatives i.e. volunteering/employment pathways etc	James, Michelle	31/07/2023	Links to 1a.3
2a.1 Identify and target development pools to support future registrant roles	Glanville, Amanda	31/12/2023	On track - development work in progress
2a.2 Scope opportunities to support development in role and identify training needs	Glanville, Amanda	31/07/2023	Scoping paper in development - on track for completion.
2a.3 Reshape higher awards process to link with training needs analysis	Glanville, Amanda	31/03/2024	On track
2a.4 Develop an interprofessional education plan with full implementation plan by 2026	Glanville, Amanda	31/03/2024	On track
2a Engage with and listen to our people to ensure we support them to thrive through healthy lifestyles and relationships	Gostling, Lisa	31/03/2024	On track
2a.1 Implement a single point of contact for health & wellbeing services with parity for physical & psychological wellbeing	Davies, Christine	Completed	On track - single gateway Well being portal launched in May 2023

2a.2 Wellbeing charters are fully embraced	Davies, Christine	Completed	On track - Task and Finish group establishes and Charter progress review underway
2a.3 Deliver kind people processes to support people in challenging times	Davies, Christine	Completed	On track - Initial review of ER action plan undertaken and first draft of opportunity cost template drawn up. Report on ER cases for 2022/23 completed
2a.4 Undertake second delivery report to listen and understand how best to aid staff retention	Davies, Christine	Completed	On track - project team established and research phase is underway
2a.5 Implement Strategic Equality Plan to enhance HD as a culturally diverse organisation	Davies, Christine	Completed	On track - Pride events being held during June and July. Nominations submitted to the Welsh Veteran's Awards with the Health Board shortlisted as a finalist in the Employer of the Year category and three staff members shortlisted in the Reservist of the Year category
2a.6 Promote and provide proactive and responsive support to teams to enable healthy and happy cultures	Davies, Christine	Completed	On track - Nurse Retention work programme updated for Phase 2 and a new Medical Staff Retention group established. ODRMs supporting working cultures across a range of sites and services
2b Continue to strive to be an employer of choice to ensure our people are happy, engaged and supported in work to further stabilise our services	Gostling, Lisa	31/03/2024	On track
2b.1 Improve HB education & development offer, supporting enhanced opportunities	Walmsley, Tracy	31/03/2024	On track
2b.2 Workforce Effectiveness and Stabilisation Programme to improve experience of staff by reducing reliance on agency/bank and recruiting to posts locally and by overseas means across all professions	Walmsley, Tracy	31/03/2024	Plans for nursing established, scoping of plans for other professional groups in progress.
2b.3 Widen choices relating to contracting opportunities	Walmsley, Tracy	31/03/2024	On track
2b.4 Enable job enrichment where appropriate; core principles and design methodology developed	Walmsley, Tracy	30/09/2023	On track
2b.5 Plan developed to optimise digital opportunity and cost effective workforce agility	Walmsley, Tracy	31/03/2024	On track

2b.6 Further develop and spread people recognition formally and informally	Walmsley, Tracy	31/03/2024	On track
2c Develop and maintain an overarching workforce, OD and partnership plan	Gostling, Lisa	31/03/2024	On track
2c.1 Implement succession planning and leadership & management pipeline	Walmsley, Tracy	31/03/2024	In progress
2c.2 Further develop short and long terms plan by services and professional groups	Walmsley, Tracy	31/03/2024	In progress linked to specific actions within the risk and wider service issues/plans on capital programmes/ Capacity challenge/prioritisation needed
2c.3 Understand our people by using quantitative and qualitative data	Walmsley, Tracy	31/08/2023	Good progress, timelines may prove a challenge to integrate all - wins will be sought for impact
2c.4 Develop a process of listening and learning from staff experiences ensuring regular feedback	Walmsley, Tracy	04/04/2024	In progress
2c.5 Promote a culture of innovation and enhance the HB reputation	Walmsley, Tracy	04/04/2024	In progress
Agree actions to mitigate strategic risks of workforce supply based on assessment paper	Gostling, Lisa	31/03/2024	Risk assessment in progress as at June 2023, with paper to follow
Explore & assess alternative roles (value, barriers and future plans (MAPS, AP's APP's, CAAPS))	Walmsley, Tracy	31/03/2024	Ongoing annual cycle of PA programme - panel complete. APP working group in place, CAAPS discussions ongoing for future years; AP assessment needed going forward links to All Wales work

Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Monitoring of workforce SIP and gaps in establishment control	1st				Assessment & continuous development mechanisms linked to Capacity and Capability (including any negative impacts on Wellbeing)	Draft Maturity Matrix and "Panel" approach to be tested	Walmsley, Tracy	~~31/05/2023~~ 30/09/2023	Draft developed to be tested with a panel and fed into PODCC for assurance
	Strategic People Planning & Education Group	1st					Overarching Implementation Plan & Assessment of Impact (Approach defined 30/9/23) and delivered no later than 31/03/24 to link to Annual Planning cycles (identified in Audit Wales initial draft report)	Walmsley, Tracy	31/03/2024	Suggested approach to be discussed: alignment of Risk, DITS (Operational plans) and Clinical Services Plan with AHMMWW strategy (Strategic plans) underpinned by stakeholders engagement on a wider workforce strategy.
	Workforce levels monitored at Service Level, Professional Groups and Operational Delivery Group & Improving Together meetings	2nd								
	PODCC - IMTP Plan, and process mapped through Planning Sub Group	2nd								
	Workforce Planning Internal Audit (Substantial Assurance) April 2022	3rd								
	Wales Audit Office review of Workforce Planning (Fieldwork underway - report expected Summer 2023)	3rd								

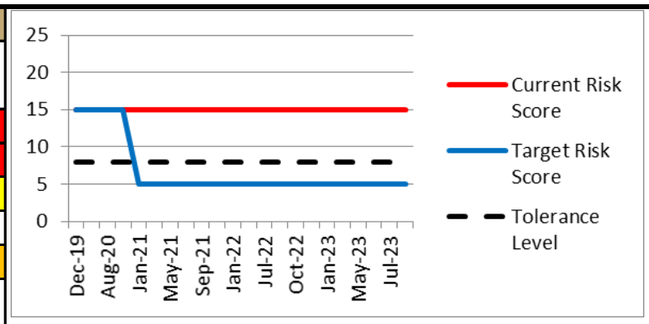
Appendix 2

Date Risk Identified:	Oct-19		
Strategic Objective:	3. Striving to deliver and develop excellent services		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Aug-23
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Sep-23

Risk ID:	**813**	**Principal Risk Description:**	There is a risk of failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO). This is caused by 1: The age, condition and scale of physical backlog, circa £20m (+) relating to fire safety (i.e. non compliant fire doors, compartmentation defects and general fire safety management issues) across our estate significantly affects our ability to comply with the requirements of the RRO in every respect. 2:Difficulties managing the actions within the current fire safety risk assessment system - to enable complete transparency and ongoing management of actions assigned to responsible persons. The new Boris system will address this issue. 3: Management responsibilities for fire safety not fully understood by all responsible managers. 4: Fire safety training attendance figures are not reaching HB agreed targets. This could lead to an impact/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement (already served on Withybush and Glangwili General Hospitals), fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?		708, 951, 503	

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the Mid and West Wales Fire and Rescue Service (MWWFRS) letters and Enforcement Notices. All programme dates have been agreed with the Health Board, Welsh Government (WG) and MWWFRS senior inspecting officers. We intend to review the progress of our completed actions to determine the risk score as we progress with these works. MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position. Extensions of time particularly for WGH Phase 1 (Aug 23 to Oct 23) and GGH Phase 1 (Aug 23 to Jan 24) have been fully agreed by MWWFRS. As of July 2023, the risk is felt to still be extreme until further progress is made on the above Fire safety improvement works. This will be reviewed regularly. There are still some significant challenges faced by the Health Board to fully comply with the fire safety order, as a result of further fire brigade inspections across the organisation and the need to address these findings within the timescales expected. Whilst the fire safety team are in a position to provide support now to the Health Board in the form of expertise and technical knowledge. The Health Board still needs to manage and address the physical backlog of fire safety across its estate.	Further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (additional surveys) that will remain until appropriate measures are put in place to address the deficit. Despite annual investment from statutory capital for fire safety components (circa £200k), the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has. It is anticipated that when training attendance levels specifically for L2 training have reached > 80% targets and are sustained at this level continuously, coupled with the completion of key fire safety investment programmes and phases across our acute sites (completing in circa April 2025), the HB will then be in an informed position to look at the reduction of risk score for risk 813. This decision will be reviewed regularly.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG. Extensive fire safety improvement works are being undertaken at WBH, GGH and at BGH from WG agreed funding (EFAB bids for BGH and funding and From submitted business cases), with phased timelines fully agreed with MWWFRS. Regular communications and dialogue is taking place between HB and MWWFRS. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy. UHB has implemented a governance structure for fire safety reporting. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety meetings. Annual prioritisation of investment against high risk backlog. Internal governance review (2019/20) initiated by the CEO and all action implemented from review. The HB has now embedded a fully resourced fire safety management team, with appropriate reporting arrangements for fire safety and addressing the backlog of out of date fire risk assessments across the UHB. The UHB has improved fire safety management culture and management ownership for fire safety.	Despite significant investments already in place following enforcement notices and letters of fire safety matters, additional investment is required to address fire safety defects at other sites within the UHB, which are being inspected by MWWFRS. We have firm plans in place to address a range of fire safety projects over the coming years and these are all fully identified as actions within this risk with anticipated timelines. Inability to allocate fire risk actions to appropriate owners on current fire risk assessment system hosted by NHS Wales Specialist Estates Services (NWSSP-SES). Inability to manage and control recommendations within the HB's own Fire Risk Assessments. Despite making improvements to the culture of fire safety management and ownership, the HB does need to ensure this is organisational wide and embedded within it's workforce and cascaded by management. Whilst the new BORIS system is now in place, fire risk assessments are still being transferred from the old system as at July 2023.	Implementation of a new software system to manage the content of the HB's fire risk assessments. Boris software has now been purchased and is currently being implemented. Date agreed as part of internal fire safety governance review.	Evans, Paul	Completed	Boris software now purchased Dec 2020, initial implementation planned for March 2021. Implementation of risk assessments will now be planned for July 2021. System now supports the use of mobile technology therefore risk assessments can be completed live on the system. System now being tested on site, fully operational by Jan (now Feb) 2022
		Additional fire surveys are required across various sites to obtain costs for all fire compartmentation defects, doors, fire alarm systems and other associated items.	Evans, Paul	Completed	fire safety team and compliance team are working with site operations to determine what the gaps are and to agree what surveys will be required.
		Introduce new innovative ways of improving fire training attendance across the HB to increase the percentage figures agreed and set by the HB. As part of the next risk review the fire team intend to split this action into individual sections so we can track and close off action as and when completed.	Evans, Paul	Completed	The fire safety team have been trialing the use of MS teams for L2 Fire training, which has proved to be very successful. We are planning to roll this out to other areas of fire training levels, such as L5/L4 & L3. This will have a positive impact on staff being able to attend the session. We will need to improve communications on this and to ensure staff are made fully aware of the sessions taking place and the dates.
		To introduce ways to help improve the culture and ownership of fire safety across the HB. Although management training is taking place at the "Managers Induction Programme" and this is well received. The HB still needs to do more to avoid areas of poor practice that is sometimes identified.	Evans, Paul	Completed	To look at improving the current training content and programme that's currently on offer for management. Regular global communications of do's and don'ts. Having a fire safety share point system, with links to interesting info on effective fire safety management.

The fire team will also look to implement a regular training global e-mail as a reminder for staff on when and how to book a session. Works already completed following issue of Enforcement Notices and LoFSM at various sites. For EN sites (WBH and GGH) - Advanced Works to vertical escape routes now completed. Also further improvements under LoFSM at Tregaron, Bronglais, Glangwili and Withybush Hospitals. Level 1 & 2 Fire Safety training is delivered via Teams. Level 3 Fire Safety training is provided face to face. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer. Level 5 training is provided on Teams as part of the H&S Managers induction training. There is an improving performance in terms of uptake of training sessions across all levels. Boris fire safety system implemented across the UHB, giving the ability to review all risks from fire risk assessments via a dashboard. Fire Team issued recent Global communications to request additional Fire Safety Wardens, to seek engagement from staff and colleagues across the Health Board. RAAC plank surveys are also being undertaken at the same time as the fire works to minimise the disruption to clinical services where at all possible.			
Now the new Boris fire safety system is being implemented across the HB (training planned for June 22 for staff), fire risk assessment actions from this need to be monitored by those responsible. These actions need to be communicated at all fire safety sub groups and fed to the HB wide FSG for complete transparency.	Evans, Paul	Completed	System now live in the HB and staff training programme in place. From this point all fire risk assessment actions will be closely monitored using this system.
Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Evans, Paul	Completed	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system trial on site by July 2021. System now being tested on site on a few Fire Risk Assessments, we plan to go fully live in Nov/Dec 2021.
Establish a teams training platform to deliver the level 3 and level 4 fire safety training programmes. Although this will also be supported by face to face sessions.	Evans, Paul	Completed	Following a review of level 3 & 4 fire safety training programmes it has been established that these cannot be delivered via Teams. These are now delivered as follows: Level 3 training has been reviewed and requires a face to face practical delivery. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer.

WBH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	~~31/01/2023~~ ~~31/03/2023~~ ~~31/08/2023~~ 31/10/2023	MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. WGH Phase 1 works is planned to be completed by October 2023.
WBH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	30/04/2025	Phase 2 works remain on programme to be completed by April 2025.
GGH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	~~28/04/2023~~ 22/01/2024	The current forecast completion date is January 2024, however this will need to be closely monitored and reviewed as the project progresses
GGH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	~~30/04/2024~~ 30/08/2024	Phase 2 remains on programme to be completed by August 2024 (subject to the full due diligence work needed as part of the Business Case development).
Develop a Fire Training information pack for distributing to agency staff across all 4 sites.	Elliott, Rob	Completed	Completed - We have supported the HoN on this recommendation and issued our current training material to all agency companies. We will continue to support the HoN with any new welcome packs they introduce.
To ensure all fire risk assessments are transferred from NWSSP-SES system to Boris	Evans, Paul	31/03/2024	To be provided at next risk review

Appendix 2

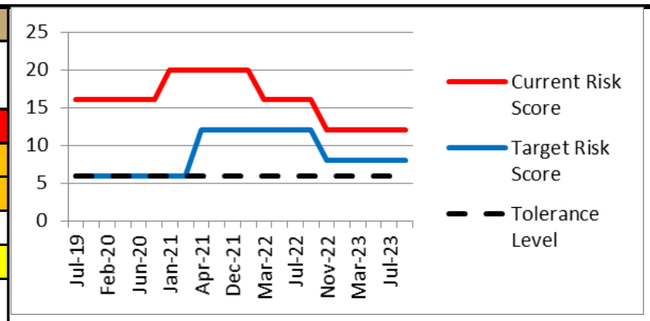
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Maintain a zero or as low as possible number of outstanding fire risk assessments.	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18 SBAR submitted to each HSAC meeting, which includes themes of all fire safety risks.	General site management checks/walkarounds on all sites				
	Site Fire wardens reporting fire safety issues	1st								
	Annual Online Fire Audit Self-Assessment submitted to NWSSP	1st								
	Review of compliance through fire safety groups	2nd								
	4 Fire Safety Sub Groups (one at each site) which report into the UHB wide Fire Safety Group (reporting into the HSC)	2nd								
	Fire Safety SBAR reports regularly issued to HSC	2nd								
	Fire inspections by Fire Service & Fire Improvement Notices	3rd								
	NWSSP fire advisor inspections	3rd								
	NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance	3rd								
	IA Fire Governance follow up in July 2022 - Substantial assurance.	3rd								
	IA WGH Fire Precautions Works: Phase 1 in Aug 22 - Reasonable rating.	3rd								
	High level action plan meeting with MWWFRS (Dec 8th 22) - with very positive comments received from then on our commitment to improve fire safety performance.	2nd								

Appendix 2

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jun-23
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

Risk ID:	**684**	**Principal Risk Description:**	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment (the general rooms and mobile fluroscopy unit in Bronglais). This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of breaches over 8 weeks due to increased downtime.
Does this risk link to any Directorate (operational) risks?		925, 114	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:

The Health Board's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and impact to patients can include delays in diagnosis and treatment. CT and MR scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience.

The risk score is noted as 12 reflecting that some equipment has been installed and is operational. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified, however funding has not been secured (for financial year 2023/24). As at June 2023, confirmation on funding was awaited.

Rationale for TARGET Risk Score:

While equipment has been installed as part of the current WG funding allocations, there is uncertainty as at November 2022 with regards to continued equipment replacements for financial year 2023/24 due to the discontinuation of a dedicated imaging equipment replacement allocation. New All Wales PACS procurement requires all equipment to be DR for compatibility. This has meant that replacement priorities have changed, and that some of the older DR compliant equipment are now overdue for replacement, and at risk of being de-prioritised.

With more modern equipment, breakdowns will be less likely and less significant in terms of downtime together with a reduced impact on the diagnostic services at the remaining hospital sites. Improved business continuity plans will also help reduce the impact of equipment breakdown across the UHB.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports.Some funding has been secured from AWCP for some replacements but does not cover all outdated equipment nor the future requirements. # Escalation process in place for service disruptions/breakdowns. # WG Funding agreed for 2 x CT scanners (GGH & WGH) - now installed # Additional CT secured in the form of a mobile van in December 2020. # Newly created National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales.	Limitation of spare parts for some older equipment leading to extended outages. This issue may be compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Competing demands for replacement equipment due to RISP, as four pieces of equipment will be non-compliant No dedicated diagnostic equipment replacement funding has meant that DCP bids are having to be developed for all equipment replacement.	Work with planning colleagues about sourcing capital funding through DCP and AWCP.	Roberts-Davies, Gail	Completed	Two business cases have been funded by WG. Further Business Cases for the further 3 CT scanners and or General Rooms (depending on priority) to be submitted in 2022/23.Submit updated paper to CEIMTSC to outline current priorities and funding requirements from DCP and AWCP. 21/12/2021 - discussion with the Head of Radiology has confirmed that all relevant funding has been sourced, with ongoing work to install equipment / updates to be made alongside the Estates time. Action complete with regards to funding.
		Installation of CT Scanner at Withybush General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. As of 25/05/2022 the installation of this equipment is currently running to schedule.
		Installation of scanner at Prince Philip Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. Installed and operational in October 2022.
		Installation of CT Scanner at Bronglais General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
		Installation of DR room in Prince Philip Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. Installed and operational in October 2022.
		Installation of DR room in Glangwili General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. Installed and operational in November 2022.

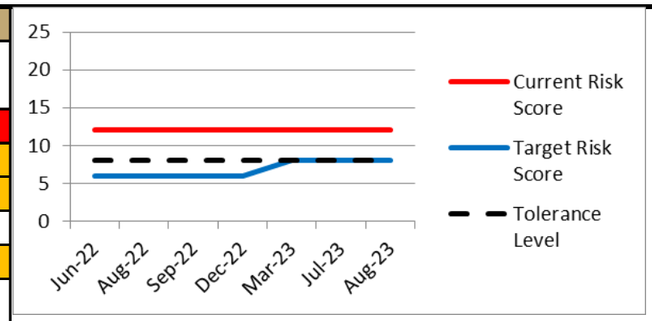
Installation of DR room in Withybush General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
Installation of fluoroscopy room in Bronglais General Hospital	Roberts-Davies, Gail	Completed	Completed in April 2023, therefore action closed.
Replacement of Mammography equipment at Prince Philip Hospital	Roberts-Davies, Gail	Completed	Completed in April 2023 therefore action to be closed
To confirm the capital funding to replace existing aged equipment for FY 2023/24	Roberts-Davies, Gail	~~31/03/2023~~ 30/06/2023	A prioritisation list of aged equipment to be replaced has been devised as at November 2022, however confirmation needed on funding in order to undertake the required work. Still awaiting funding outcomes as at June 2023.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 6 weeks by Mar22. Reduction in overtime costs to nil by Mar22.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20	Lack of process of formal post breakdown review.				
	IPAR report overseen by PPPAC and Board bi-monthly	2nd								
	Internal Review of Radiology Service Report (Reasonable Rating	3rd								
	WAO Review of Radiology - Apr17	3rd								
	External Review of Radiology - Jul18	3rd								

Date Risk Identified:	Feb-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Aug-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Oct-23

Risk ID:	**1350**	**Principal Risk Description:**	There is a risk of the Health Board not being able to meet the 75% target for waiting times in the ministerial measures for 2022/26 for the Single Cancer Pathway (SCP). This is caused by capacity challenges within the first 28 days of the pathway in first Outpatients Assessment and diagnostics, particularly in the large volume tumour sites, lower GI and urology, gynaecology & skin. Resulting in patients waiting in excess of 62 days. This could lead to an impact/affect on increased number of patients waiting in excess of 62 days and meeting patient expectations in regard to timely access for appropriate treatment which could potentially lead to poorer outcomes and patient experience, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from Welsh Government.
Does this risk link to any Directorate (operational) risks?		1223, 114, 111, 1537, 1699	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:

Cancer performance has been variable since quarter 3 2021/22. Lower than predicted performance in the last three months (period to July 2023) has been driven by high number of patients treated beyond target in a number of specialties, particularly in Urology, LGI, and Lung cancers. The Backlog has decreased to 379, which includes tertiary in July 23 (July 22: 786). The overall backlog in July 2023 decreased by 52 from the previous month. Performance is below prediction and currently at 46% for June 2023, against predicted performance of 60%. The predicted backlog for March 2024 is 236, with a predicted performance of 70% by the financial year end.

The declaration of an Internal Major incident at Withybush General Hospital in August 2023 as a result of Reinforced Autoclaved Aerated Concrete (RAAC) requires pathway changes in surgical specialities to alternative sites. This will require enhanced monitoring to mitigate impact on performance.

Rationale for TARGET Risk Score:

The aim is to treat patients within target waiting times, which has now been confirmed as 75% non-adjusted 2022-2026.

The tolerance level will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. Publication of performance data by WG recommenced in Feb21 with health boards only reporting against the SCP, with no wait adjustment.

Target risk score amended in March 2023 to reflect that current trajectories for March 2024 aims to achieve 70%, recognising that there is still further work to be done to achieve the ministerial requirement of 75%.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with access for Cancer Services staff and Service Managers, allowing MDTs to actively monitor tumour site specific patients on a SCP. # A Rapid Diagnosis Clinic (RDC) has been launched within the health board. Currently 1 clinic per week being held in PPH. # Funding has now been secured and plans are being discussed to role this service out across all 3 counties. # As per the Wales Bowel Cancer Initiative, a successful FIT10 screening in the management of USC patients on a colorectal pathway was implemented in June 2020. This initiative was rolled out to primary care by the endoscopy service on 6th April 2023. For June 2023, 88% of tests were returned. 27% were for OPA, 13% for further diagnostic tests and 18% negative - Discharged back to GP # Digital Delivery of Care was implemented during the first wave of the pandemic, resulting in two thirds of patients receiving virtual appointments and only a third requiring face to face appointments. # Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. # Weekly Cancer Watchtower meetings where services managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues. # Monthly performance meetings with Welsh Government. # Trajectory performance plans have been developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved.	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP. Key diagnostic information systems do not support effective demand / capacity planning. Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	The Wales Cancer Network are employing Single Cancer Pathway (SCP) Project Managers for each health board across Wales to support the SCP work and the optimisation of the National Optimal Pathways	Humphrey, Lisa	Completed	Project Manager appointed and took up post in Apr22. This will be a 2 year fixed term appointment to run alongside the optimisation project. Request made 18th November to the WCN for sessions to develop and strengthen our Cancer Recovery plan and maximise optimum pathway opportunities
		Work with newly appointed Head of Radiology to: 1) explore outsourcing opportunities and internal solutions to increase capacity to appointments and reporting utilising non recurrent recovery money. 2) Investigating current capacity for diagnostics to ensure a 7-day turnaround as per the National Optimal Pathways.	Humphrey, Lisa	~~31/03/2023~~ ~~31/07/2023~~ 30/11/2023	Work in relation to Demand and Capacity within the Radiology Directorate is ongoing.
		Review access to green surgical pathways across all sites to include access to green critical care.	Humphrey, Lisa	Completed	As of March 2023, service now operating as at pre-covid capacity. Action complete.
		Introduce a central point of contact for navigator as a pilot to coordinate radiology USC appointments and reporting from Mar22	Humphrey, Lisa	Completed	The Radiology Navigator took up post in April 22.

# Weekly monitoring of Urology diagnostic improvement trajectory via Cancer watchtower. # Cancer Pathway Review Panel has been implemented to identify any risk for those patients who have not received their treatment within 146 days. # Process in place that improves time for patients to first outpatient appointment to improve the 28 day performance target (all patients to be informed etc). # Deep dive pathway review for poorest performing tumour sites - urology, lower GI, gynaecology. # Continue to escalate concerns regarding tertiary centre capacity and associated delays. Improvement Cymru and NHS Executive support re straight to test, accelerated imaging and Endoscopy efficiency improvements. Same day access from Endoscopy to CT (same day staging) to commence 4th September 2023. # Digital process for Pathology MDT with Swansea Bay commenced in May 2023 and piloted for gynaecology cancer services. Already started with Lymphoma patients. # Quarterly Improving Together sessions (DITS) with Executive attendance.		Each MDT to review and adopt recommended optimal tumour site specific pathways. (Timescales may change depending on COVID)	Humphrey, Lisa	~~31/03/2023~~ ~~30/09/2023~~ 31/03/2024	The Macmillan Cancer Quality Improvement Manager is working with the teams with regards to implementing the new pathways.

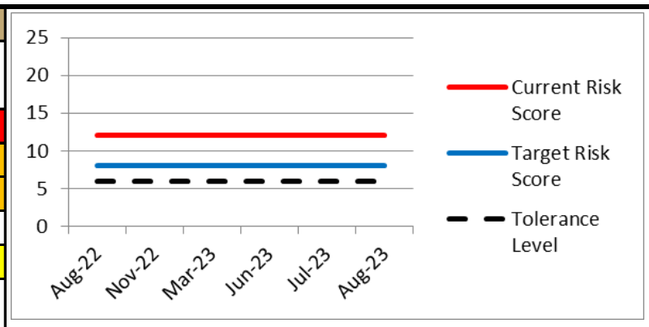
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Internal targets - Looking at the performance per tumour site individually concentrating on those tumour sites under 50% ie Gynae, Lower GI and Urology. Monitoring the 28 day performance and overall performance for each tumour site.	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Nov22	None identified.				
	Monitor outpatient appointments booked beyond 10 days to identify common themes	1st								
	Service plans in response to COVID-19 overseen and agreed by Bronze Acute & Gold (when instigated)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	Monthly oversight by Delivery Unit, WG	3rd								

Appendix 2

Date Risk Identified:	May-22	**Executive Director Owner:**	Gjini, Ardiana	**Date of Review:**	Jun-23
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	Aug-23

Risk ID:	**1433**	**Principal Risk Description:**	There is a risk the Health Board being unable to maintain routine and emergency service provision across the organisation in the event of a severe pandemic event. This is caused by a novel virus (or emerging variant or mutation of concern) causing a pandemic as declared by the World Health Organisation (WHO) and the subsequent ability of the Health Board to respond to the scale and severity of the outbreak. This could lead to an impact/affect on patients being able to access appropriate and timely treatment, the UHB being able to maintain safe and effective levels of staffing, financial loss, adverse publicity/reduction in stakeholder confidence, increased mortality and ill-health across our population.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The national security and risk assessment was reviewed and re-published in November 2022. The previous pandemic influenza risk has been changed into 2 new risks, one generic pandemic event and 2 emerging infectious diseases. Current likelihood scored at a 3 to reflect the risk of the Health Board being unable to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring.

Rationale for TARGET Risk Score:
A Cabinet Review of Influenza Preparedness was due just prior to COVID-19 which delayed publication. This workstream has now recommenced and together with outcomes and learning points from COVID-19 will inform our future planning approach for pandemic response. It is hoped to reduce either the likelihood and/or impact score following consideration and implementation of these reviews/recommendations and subsequent review of internal planning arrangements.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Major Incident Plan # Well established command and control structures for managing pandemic response both nationally and locally # Continuation of current COVID-19 national vaccination programme until at least March 2023 # Future service model for contact tracing and testing in place until March 2023 # Extensive knowledge across Health Board in managing a pandemic event # COVID-19 response measures which can be adapted to respond to any future pandemic event # Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza (approved by Strategic LRF 14/11/18 now under review) # LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Strategic Group on 11/07/2018. Will be reviewed imminently via LRF Health Group. # Health Board Pandemic Influenza Response Framework and associated plan(currently outdated awaiting review) # Quality assurance process via national & local exercise programmes. # Access to national counter measures stockpile # Surge Plans in place to enable HB to respond to future spikes/waves of infection requiring recommencement of contact tracing, testing & vaccination # Continuous learning from COVID-19	# Current Health Board pandemic framework will need to be updated to incorporate new Cabinet Office review implications/ recommendations and broaden remit to generic pandemic response rather than be influenza specific. # Current response measures, especially around contact tracing, testing and vaccination are time limited and currently in the process of being stood down. Will need to be re-established to respond to future pandemic situation.	Health Protection Manager tasked to lead re-establishment of HB Pandemic Planning Group and review of Pandemic Response Framework.	Hussell, Sam	30/09/2023	Progress to be provided at next risk review.

Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Planning via Emergency Preparedness, Resilience & Response (EPRR) inc LRF workstream reports to Health & Safety Assurance Committee	1st			TTP Updates to Board on a regular basis. Vaccination Delivery Programme Update - Board (Jul22) Major Incident Plan - Board (Jul22)	None identified.				
	Operational pandemic reporting structures from HB to WG	2nd								
	National, regional & local command & control structures	2nd								
	National groups operational for vaccination programme planning & delivery	3rd								
	Emergency Planning Advisory Group (EPAG) Wales meetings re Pandemic response and future planning	3rd								

Appendix 2

Date Risk Identified:	Jul-23		
Strategic Objective:			

Executive Director Owner:	Paterson, Jill	**Date of Review:**	Aug-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Oct-23

Risk ID:	**1708**	**Principal Risk Description:**	There is a risk of increasing fragility in Primary Care Contractor services. This is caused by challenges in recruiting new clinicians into salaried or partnership roles which impacts on succession planning for contractor professions. There are further challenges in relation to premises not being fit for purpose and not having the capacity to flex to a more modern approach to service delivery e.g. MDT working. In addition, contract reform against the background of significant pressures on the wider system, and exacerbated by financial pressures for the independent contractor business model. This could lead to an impact/affect on undermining the independent contractor model, and therefore the ability for patients to access timely and local primary care services. If service users are unable to access these services, this may lead to additional pressures on other primary care services, and wider Health Board services such as Out of Hours and Urgent and Emergency Care.
Does this risk link to any Directorate (operational) risks?	1688, 1451, 1403, 1164, 1660, 933		

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Service/Business interruption/disruption	
Inherent Risk Score (L x I):	4×4=16	
Current Risk Score (L x I):	4×3=12	
Target Risk Score (L x I):	2×4=8	
Tolerable Risk:	6	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:
Dental: current contract discussions and implementation of contract reform has led to a destabilisation of NHS Dentistry in Hywel Dda. Community Pharmacy: inability to secure locums and rising locum costs have impacted on the delivery of services and led to branch closures; in addition there have been some changes with the multiple groups that have had some impact on service provision GMS: ongoing recruitment issues with the partnership model has seen a destabilisation of the workforce particularly within smaller GP Practices.

Rationale for TARGET Risk Score:
Achievement of the target score is subject to the development and agreement of a Primary Care Strategy at Board alongside successful national contract negotiations and subsequent implementation across the Primary Care contractor professional groups.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements 0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS Escalation tool for GMS and Community Pharmacy (SITREP) Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices. Programme of practice visits to review Estates provision, and if remedial action is required Nationally agreed Breach Management process in place for Community	A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services. Requests for support on addressing the GMS sustainability agenda are with the Strategic Programme for Primary Care as a result of a review paper across all Health Boards on their sustainability pressures. National work on the development of the escalation tool for Dental and Optometry is ongoing but not live. Five Facet Survey and annual reporting of practices has highlighted non-compliance with statutory requirements such as Health and Safety, Fire and IP&C which have now all been addressed.	Establish workforce plan and recruitment strategy in line with the development of the national Primary Care Workforce Strategy and as a component of the Primary Care Strategy.	Hughes, Samantha	31/03/2024	To be updated at next review.
		To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including: •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions	Bond, Rhian	09/01/2024	Outline proposal for strategy along with timeline discussed with Execs. Work in train for developing an issues paper for September 2023.
		Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.	Owens, Mary	30/04/2024	Modelling is ongoing.

Pharmacies. Requests for contract variation (termination, merger, branch surgery closure etc) are considered in line with national guidance, with panels convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required.		Limited requirements for practices to disclose information to the Health Board about their sustainability pressures, and rare for practices to disclose financial details (reliant on engagement and good will as this is not a contractual requirement as at June 2023). Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors. Whilst Community Pharmacy Breach Management process in place, 2 notices are currently under the appeals process - the Health Board is awaiting confirmation on the outcomes of these by Welsh Government, which to date has taken 10 months. Outcomes of these appeal will directly influence the approach taken going forward, and may result in the natioanlly agreed process unable to be fully implemented.	Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	04/01/2024	Currently progressing the tender action for Neyland and Johnstown practice, due by September 2023.

Appendix 2

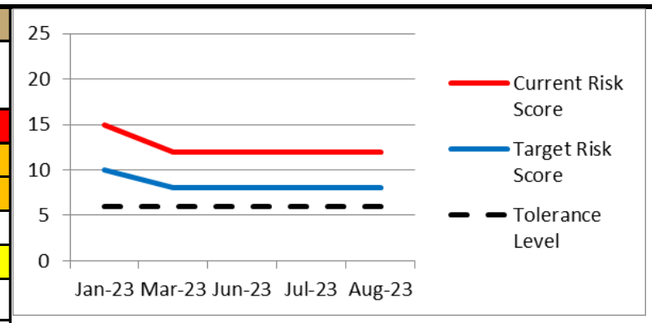
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Sustainability Matrix Contract performance to monitor volume metrics (identifies if dental practices have issues in service delivery) Monthly assurance reports and Dental Assurance Framework - Business Service Authority dashboards, to identify outliers	GMS practices are asked to complete a WG sustainability matrix every 6 months to track the main risk areas and this contributes to a heatmap. Practices are also asked to report regularly on operational pressures	1st			OQSEC Primary Care Exception Report (Jun 23)	Varying levels of engagement from practices in the regular reporting of operational pressures.				
	Dental Management Team undertake annual reviews	1st								
	GMS Practices are part of a rolling visiting programme, based on their annual return which is risk assessed against a framework of any other issues or concerns identified	1st								

Appendix 2

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Gjini, Ardiana	**Date of Review:**	Jun-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Aug-23

Risk ID:	**1559**	**Principal Risk Description:**	There is a risk of the Health Board being unable to maintain all areas of health board business including routine, urgent and emergency service provision, corporate and administrative functions across health board sites and in our communities/patient's homes in the event of planned and unplanned power outages. This is caused by by supply failure by energy suppliers or severe weather events. This could lead to an impact/affect on patient care, patient safety and delivery of services (including medical devices and equipment). Additionally this could also impact delivery of the Health Boards delivery plan.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:

Risk from power outages has been highlighted at UK level in the National Security and Risk Register and also at regional level in the Dyfed Powys Local Resilience Forum Community Risk Assessment. Welsh Government is working with UK Government on the resilience of the energy system. In line with standard practice, the systems operators for gas and electricity have completed their winter outlooks. Their central scenarios, based on the functioning of normal market conditions, suggest there will be sufficient margins across both gas and electricity. However, there is recognition that we face unprecedented threats to the normal operation of energy markets. The key threat being the impact of supply restrictions of Russian gas to mainland Europe and the impact this has on rest of the world supplies and energy trading arrangements from mainland Europe into the UK. This on top of traditional winter risks (low renewable energy generation, major infrastructure failure and high demand as a result of colder weather) mean there is a reasonable worst-case scenario where emergency measures are enacted. The Health Board has a number of measures in place to respond to such events, however assurance is being sought on wider impacts which may affect the Health Board's delivery of safe patient care. The current risk score remains due to the intelligence gathered and mitigation measures in place.

Rationale for TARGET Risk Score:

The target score has been reduced as the controls that will be put in place are aimed to reduce the likelihood of impact to patient safety and patient care.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS** **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Power Outage Planning Group established. Hospital Sites (all in-patient facilities): Generator provision on inpatient sites (200 hours running time) EFAB bid approved to install plug-in generator connection points on acute hospital sites. Works to be completed by Autumn 2023. Generator maintenance contract with Power Electric. Planned generator maintenance and testing programme in place. Diesel polishing programme underway for bunkered diesel supplies. Acute sites listed on energy provider Protected Supply List (excluding BGH) Rota load disconnection process - all acute sites covered plus AVH and LCH. Primary and Community Care: Out of Hours Service able to operate in all but one base (Llandysul) as located on acute hospital sites. Confirmation of little/no generator provision across primary care. Primary care to manage via their business continuity plans. Local Resilience Forum: Multi agency planning group considering power outage preparedness Regional table top exercise held on 16 Feb 23 (Exercise Lemur) National Tier 1 exercise planned for 28-30 Mar23 (Exercise Mighty Oak) Details of levels of contingency measures within individual care plans in the community determined.	Hospital Sites: Back up generators on inpatient sites - only one per site in place rather than the recommended two per site. Generator connection points to enable portable generators to be connected in times of primary generator failure. Other: Contingency measures for ICT capability and loss of power across health board sites and remote workers for those staff who work from home Community tensions Potential impact on HB premises, eg public accessing sites for power, warmth and communications Development of Communications Strategy Assurances from partner agencies	Strengthening generator provision across all Health Board facilities.	Elliott, Rob	~~31/03/2023~~ 31/10/2023	EFAB bid successful for generator connection points on acute hospital sites with work to be completed by Autumn 2023. Capital bid for additional generators. Bid to be developed for purchase of back-up generator that could be located on any hospital site as needed.
		Clarification on facilities on the Protected Supply List to be sought.	Elliott, Rob	~~31/01/2023~~ ~~30/04/2023~~ 30/09/2023	Challenge on decision to not include BGH on the Protected Supply list submitted to energy provider. Further discussions relating to technical specifications taking place.
		Communications plan to be developed as and when further clarity on potential outages is known.	Hughes-Moakes, Alwena	~~28/02/2023~~ ~~30/04/2023~~ 30/04/2024	Will be developed as and when needed.
		Assurance on levels of contingency measures contained within Social Care (Care Homes and Dom Care packages) to determine any knock-on impact to Health Board.	Paterson, Jill	~~31/01/2023~~ ~~28/02/2023~~ ~~30/04/2023~~ 30/09/2023	Head of Long Term Care progressing.
		Assurance on levels of ICT system resilience and contingencies	Tracey, Anthony	~~31/01/2023~~ ~~30/04/2023~~ 30/09/2023	In progress.
		Power Outage Response Framework to be developed to co-ordinate Health Board response.	Hussell, Sam	30/09/2023	In Progress

Appendix 2

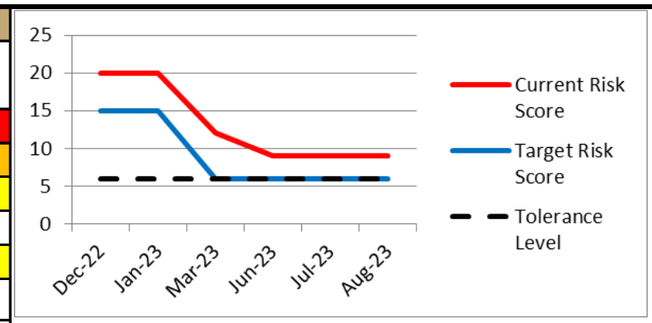
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Power Outage Planning Group established.	1st								
	Regular updates to Executive Team and OPDP.	2nd								
	Dyfed Powys Local Resilience Forum responding to risk.	3rd								
	Dyfed Powys LRF regional Exercise Lemur focusing on power outages held Feb 2023.	3rd								
	National Tier 1 Exercise Mighty Oak focusing on power outages planned for March 2023 - being led by the Cabinet Office and Emergency Planning College.	3rd								

Appendix 2

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Gjini, Ardiana	**Date of Review:**	Sep-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-23

Risk ID:	**1548**	**Principal Risk Description:**	There is a risk of the Health Board being unable to maintain routine, urgent and emergency service provision across the organisation in the event of industrial action by Health Board staff and staff in other NHS/partner organisations, eg WAST. This is caused by the BMA initiating the process to commence industrial action. This could lead to an impact/affect on patient care, patient safety, delivery of services and organisational reputation. Additionally this could also impact delivery of the Health Board's delivery plan, waiting lists (and associated initiatives) and financial position.
Does this risk link to any Directorate (operational) risks?		1027, 1407, 1550, 1641, 1666	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:
The Royal College of Nursing (RCN) and the Society of Radiographers have accepted the enhancements to the non-pay elements of the pay offer. This concludes the Industrial Action for A4C staff. However, the BMA have declined an offer of 5% uplift (1.5% uplift for SAS Doctors on the 2021 contract) for 2023/24 to basic pay and ballot notices are expected to be received by employers shortly. This covers three groups: SAS Doctors, Consultants and Junior Doctors. The BMA are expected to reach the 50% threshold for action. Welsh Government (WG) have been notified of the dispute directly by the BMA. Mitigation and contingency measures, together with command and control structures put in place during periods of previous action by Trade Unions resulted in a co-ordinated response to minimise impact as far as possible, and these will be re-established once industrial action is confirmed. The risk score has been increased to reflect the current position and the instigation of formal notification of intention to ballot.

Rationale for TARGET Risk Score:
The likelihood has been increased as the BMA has commenced the formal notification process of intention to ballot. Executive ownership is joint (Directors of Public Health, Workforce and Operations) but will be supported by the Medical Director and Director of Nursing, Quality and Patient Experience as required.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Industrial Action Planning Group formed for planning, developing contingency measures and response arrangements. Command & Control structures in place at local, regional and national level. Proactive compilation of critical service areas from a HB perspective (based on Essential Services Guide) completed. Process developed for scoping scale of staff intentions to take industrial action in place. Process developed for scoping of staff groups in planned action in place. Data capture process in place to determine impact on service delivery, patient care and financial position. Process for measurement of "harm" agreed. Communication strategic approach agreed with staff FAQs, public communications, internal staff communications and partner agencies. Guide for line managers and staff on understanding the derogation process and response developed. Range of contingency measures ready should any derogations be refused.	Clarity regarding the intentions of the BMA until the ballot notices are received.	Specific response plans will be developed following notification from the B,A on dates they intend to take strike action on. These will include early contact with BMA; derogation process; student arrangements; and links to national process. The updating of previous key controls will be instigated as necessary to prepare for potential actions.	Gjini, Ardiana	~~05/06/2023~~ ~~21/08/2023~~ 05/11/2023	Will make initial preparations and further progress as and when strike dates announced.
		To secure medical representation on Industrial Action Planning Group	Gjini, Ardiana	30/09/2023	Progress to be provided at next risk review
		To confirm new chair and vice chair of Industrial Action Planning Group	Gjini, Ardiana	30/09/2023	Progress to be provided at next risk review

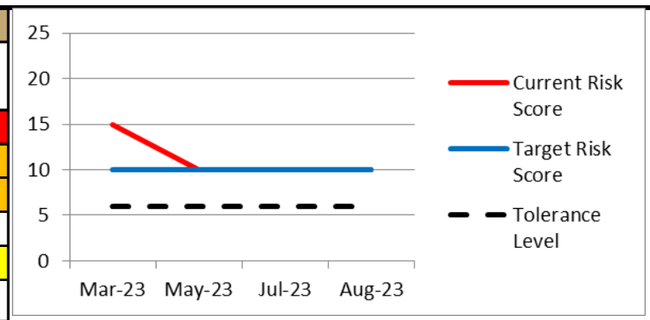
Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Industrial Action Planning Group Meeting daily	1st								
	Regular updates to Executive Team and OPDP	1st								

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jul-23
Strategic Objective:		**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Sep-23

Risk ID:	**1531**	**Principal Risk Description:**	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH. This is caused by vacancies and long-term sickness across the General Surgery Consultant rota (1:5) at WGH and reduced capacity to support rotas internally (BGH/GGH Consultants). This could lead to an impact/affect on the ability to continue general surgery at WGH, patient experience, clinical delays, deterioration, and outcomes for patients, the wellbeing of remaining consultants who are already working to full capacity and increased expenditure on agency locum consultants.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	2×5=10
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The current risk score has been reviewed in July 2023, and remains the same to reflect the Board decision in March 2023 to introduce 1 in 3 consultant on-call rota at WGH. There are currently 2 substantive consultants on the rota and 1 locum. Since the introduction of the out of hours pathway there have been limited transfers to date. The new rota is under constant monitoring and review to ascertain and address any issues. There is continued concern raised regarding the travelling time for a transfer to BGH out of hours.

Rationale for TARGET Risk Score:
The Board approved a proposal to introduce a 1:3 day-time consultant on-call rota from May 2023 which will make the rota safe. From 5pm-9am weekdays and 5pm, Friday to 9am, Monday, consultant on-call will be provided by either BGH or GGH which will reduce the risk to the Target Risk Score, however this will not address the longer term sustainability of the rota. This will prioritised as part of the development of the Clinical Service Plan in 2023/24.

Appendix 2

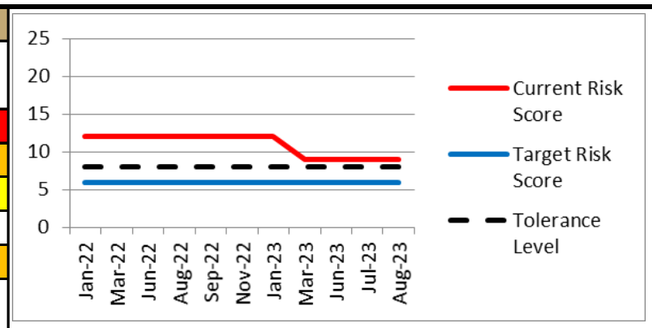
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Actively recruiting to two vacant locum consultant posts. Current staff backfill with locum consultants to maintain the rota. Requests with agency for consultant cover. Continuously liaison with the rota coordinator at WGH for potential gaps on the rota. Proactive sickness management Escalation to clinical leads Engagement with WGH Medical Staff Committee and public on changes to services Board approval on 31Mar23 to introduce a contingency model of 1:3 rota to WGH with out of hours support from BGH/GGH from 01May23 All transfers are recorded and concerns managed appropriately.	Recruitment took place of 2 locum consultants, however, they have both since withdrawn. Concerns raised about a transfer, which is being managed by an IMG process. Vacancies remain due to inability to appoint permanent Consultants to WGH. Due to the fragility of the on call rota there is limited elective capacity for locum consultants, which makes this post less attractive than other Health Boards. Reduced capacity to support this rota internally (BGH/GGH Consultants). Prolonged change to rota may impact on training of surgical doctors in WGH. Concerns from WGH physicians on the wider implications on the emergency service model at WGH	Recruitment of 2 x substantive and 1 x locum positions	Lewis, Caroline	Completed	The recruitment of 2 locum consultants was successful in May 2023. On week commencing 3rd July, the two locums withdrew. 1 due to not wishing to join the health board and the other candidate had been promoted from a specialty doctor post and would have been £40k worse off, so has made the decision not to progress. Discussions ongoing regarding what the plan will be regarding recruitment, moving forward.
		To introduce a contingency model of day time consultant on-call rota in WGH with support from GGH and BGH consultant cover out of hours.	Lewis, Caroline	Completed	Report discussed at Acute Leadership Group, Executive Team and Operational Planning and Delivery Programme (OPDP) meetings. A 1:3 rota was agreed and will commence from 01May23.
		Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	31/12/2023	We have now received the final GIRFT report and the action plan has been received at executive level. A full action plan is now supported and clinically led by the health board general surgical clinical lead, nursing and operational teams.
		Robust plans to be developed for transfer and repatriation of patients	Lewis, Caroline	Completed	SOP has been developed and discussed with clinicians.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23) General Surgery Report to Board (Mar23)	Assurance to Board on communication and repatriation arrangements	Produce update report to Board in May23 to include details on communications with clinicians and the public, details of repatriation arrangements and accommodation and support for families, the patient experience and the governance arrangements for onward scrutiny	Lewis, Caroline	Completed	on 10/05/2023, an update was provided to Ben Rogers of the clinical services programme for the draft SBAR clinical services update which is what was taken to board.
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd								
	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd								
	Assurance to be reported to the Board following introduction of temporary rota	2nd								
	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited									

Date Risk Identified:	Oct-21	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jun-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Sustainable Resources Committee	**Date of Next Review:**	Aug-23

Risk ID:	**1335**	**Principal Risk Description:**	There is a risk of clinical services being unable to access paper patient records, at the correct time and place in order to make the right clinical decisions and provide effective patient care. This is caused by not having a fit for purpose records management infrastructure along with organisational management arrangements which are insufficient in capacity and scope. This could lead to an impact/affect on the interruption to clinical services, ability to provide effective patient care including compliance with and attainment of nationally agreed Cancer, RTT and Stroke targets, review and fine by the ICO (<£17.5m - £35m fine per episode), increased litigation and negligence claims, complaints and possible redress, non-compliance with GDPR in regards access to patient information, underutilisation of clinical staff, outpatient facilities and day case areas and theatres, inappropriate disclosure of confidential information, missing patient information and confidential documentation, and non-compliance with nationally agreed retention timescales.
Does this risk link to any Directorate (operational) risks?		1434, 1427, 1369, 939,1247, 1419,1445,1627, 708, 1282, 1627	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×3=9
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	8
Trend:	



Rationale for CURRENT Risk Score:
Currently across the Health Board there is a considerable variance in both practice and process, operationally when utilising and dealing with the various types of records in use throughout directorates, services and departments. The current records management methodology, results in a non-standardised approach to delivering effective records management arrangements. With a lack of agreed criteria in terms of managing the record during its life cycle from creation, during retention and to disposable. There is a requirement for an investment in a modern day solution and an alteration to culture and attitude that will embrace change and technology associated with a digital health record (DHR), to manage the risk. The Health Board has selected its electronic document management system (EDMS) supplier, and work has commenced on scanning legacy documents in to a development environment.

Rationale for TARGET Risk Score:
The implementation of a full DHR will support and resolve a number of issues currently being experienced across the Health Board. Prior to making a record digital all services and identified IAO's will have to undertake a full review of their records management arrangements and work in conjunction with a robust criteria to ensure processes follow a standardised approach. A DHR resolves any issues we may currently be experiencing with regards the lack of storage capacity, provision of records in line with GDPR requirements, the ability to facilitate additional clinical requests, the transition to a virtual world, cost benefits, as well as many others. To assist implementation a requirement for adaptation to working practice and a considerable change in culture for future success.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Health Board Information Asset Register Identified Information Asset Owners (IAOs) Health Records Policies, Procedures and SOPs Some digitalisation projects commenced, eg, physiotherapy, A&E cards Health Board e-nursing documentation implementation Planning Objective 5M aligned to SDODC for reporting Electronic systems including: WPAS (Welsh Patient Administration System), WCP (Welsh Clinical Portal), PACS (Radiology), LIMS (Pathology), WAP e-referrals (Welsh Admin Portal), CANIS (Cancer), Diabetes 3, Selma Acquired additional storage facilities to both accommodate excess paper records and establishing a scanning bureau Acquisition of a electronic document management system (EDMS). Lease of a second storage facility Scanning of 308,000 non active patient records DPIAs undertaken on the three contractors for scanning providers, with an additional DPIA being undertaken in June 2023 in relation to RICOH Local Project Steering Group, which meets fortnightly and chaired by Deputy Director of Operations and attended by the Digital Director Programme risk register reviewed at Local Project Steering Group Cataloguing exercise undertaken for the sub-contractor with RICOH	In its paper form, the health record is not under the accountability of any one Executive and hence the degree of influence is potentially compromised. Reduced understanding or records types (across various services) and those appropriate for scanning, long term storage or destruction, leading to a non-consistent criteria for records management during the records life cycle from creation, to retention and ultimate destruction. With the requirement to implement and standardise health records protocols across all services.	Develop and implement scanned health record solution over the next 12 years depending on the split between determination of scanning and deep storage (DHR).	Carruthers, Andrew	31/03/2033	Ã‚£300k per annum for three years made available to prime the project to include acquiring premises to facilitate a scanning bureau along with appointment of a project manager. A paper outlining the direction of travel and key steps to be taken was presented to executive team 28 July 2021 and this was broadly supported. A project implementation plan along with specification for acquiring scanners is being progressed.
		Review current records management arrangements for records that are not within the scope and responsibility of the Central Health Records function. This will require agreement on future record management arrangements, required resources and project support going forward as an essential precursor to the delivering the scanning phase of the project plan. This will be largely driven by individual information asset owners providing comprehensive schedules of information assets under their responsibility.	Carruthers, Andrew	Completed	SBAR submitted to Executive Team in October 2022 outlining the plan for future records management arrangements. Further discussions are now required to fully implement the transition and move records to one centralised locality.
		Director of Operations to meet with Executive Leads with professional responsibility for clinical records to determine agreement on future record management arrangements, required resources and project support. This will be largely driven by individual information asset owners providing comprehensive schedules of information assets under their responsibility.	Carruthers, Andrew	~~31/03/2023~~ 30/09/2023	Meeting to be arranged.

Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Information Asset Owner Registers Group	1st			Records Storage SBAR - Executive Team (Jul21)					
	Digital Health Records Project Group to oversee delivery of enabling work	2nd								
	SDODC overseeing delivery of Planning Objective 5M	2nd								
	IA Records Management Report (limited - follow up (reasonable) in Health Records only	3rd								

Appendix 2

Date Risk Identified:	May-23	**Executive Director Owner:**	Davies, Lee	**Date of Review:**	Aug-23
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Oct-23

Risk ID:	**1707**	**Principal Risk Description:**	There is a risk that the Health Board will breach its statutory duty to breakeven against the Capital Resource Limit (CRL) in 2023/24. This is caused by the pressures being placed on the capital resource available in year by the need to underwrite the current expenditure on the Withybush General Hospital (WGH) Phase 1 Fire Scheme and the requirement to undertake survey works in WGH on the condition of reinforced autoclaved aerated concrete (RAAC) planks and the need to undertake remedial works. This is exacerbated by uncertainty on additional funding by Welsh Government to support these streams of work as at July 2023. This could lead to an impact/affect on the Health Board's ability to undertake/progress other capital projects which could impact on the Health Board's ability to resolve immediate issues and problems in patient environments and the ability to undertake clinical work on all sites if equipment breakdowns occur.
Does this risk link to any Directorate (operational) risks?		1382, 1596, 1539, 1096, 1040	

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Statutory duty/inspections	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	2×4=8	
Target Risk Score (L x I):	2×4=8	
Tolerable Risk:	8	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:
The Health Board's CRL is under significant pressure due to the fact that the Health Board is currently underwriting the overspend on WGH Phase 1 Fire Schemes along with picking up the cost of the RAAC survey and remedial works. The Health Board has already had to review it's approved capital programme for 2023/24 to manage these costs in the short term. Without any additional capital support from Welsh Government for these schemes, it remains likely that the Health Board will breach it's CRL and be unable to deal with emergency issues and breakdowns as they arise in year. WG confirmation has now been received for WGH Phase 1 Fire Schemes and RAAC remedial works in WGH.

Rationale for TARGET Risk Score:
The Health Board will strive to manage it's capital expenditure in line with the CRL but this will result in the Health Board having to reprioritise the investment in the Capital Programme approved by Board in March 2023. Indication from WG in the Capital Review meeting held on 21st July 2023 that funding of the fire scheme in WGH is likely and that they will also consider a submission by the UHB for RAAC funding in 2023/24.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. Timely financial reporting to Capital Monitoring Group, Capital Sub-Committee, Strategic Development and Operational Delivery Committee, Sustainable Resources Committee, Board and Welsh Government as key areas of concern emerge. 2. Bi-Monthly reporting to the Capital Sub-Committee, Strategic Development and Operational Delivery Committee and Sustainable Resources Committee regarding the capital risk. 3. Accountable Officer Letter issued to WG. 4. Regular updates to WG on the pressures on the DCP and the impact of RAAC costs.	Aligning the reporting of the risk and the potential impact between the Board Committees, ensuring that the reporting into SDODC reflects the potential impact on the delivery against the fire notices reported into Health and Safety Committee.	Ensure that the content of the SDODC reports and the DCP pressures reflects any potential impact on the delivery of the Fire Schemes.	Williams, Paul	Completed	SDODC report in August to reflect. Progress on the Fire Schemes were not impacted by the need to defer expenditure on the discretionary capital programme. Funding approval letters have now been received for WGH Fire Scheme Phase 1 and RAAC remedial works at WGH.
		Review with WG potential for additional capital to support the RAAC remedial works.	Williams, Paul	Completed	WG have asked the UHB to submit an estimate of the likely costs in 2023/24 for funding consideration. WG funding approval letter received 29th August 2023.
		May be the need to re-prioritise the DCP again following Capital Review Meeting with WG in July.	Williams, Paul	Completed	Ongoing meeting of a sub-group of the Capital Planning Group meeting every 2 weeks to review schemes on hold and bids against the contingency reserve. Funding approval letters have now been received for WGH Fire Scheme Phase 1 and RAAC remedial works in WGH in August 2023. This will mean that we can revisit the schemes on hold and pushed into 24/25.

Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against the Capital Resource Limit.	Performance against plan monitored through Capital Monitoring Group with key internal stakeholders	1st			Executive Team 21/06/2023 SDODC 26/06/2023					
	Review of RAAC costs and impact on DCP at the end of each survey stage	1st								
	Performance reports through to Capital Sub-Committee	1st								
	SDODC oversight of performance	2nd								
	Accountable Officer Letter to WG	3rd								

Date Risk Identified:	Apr-19		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Sep-23
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Oct-23

Risk ID:	**1382**	**Principal Risk Description:**	There is a risk of harm to patients and staff at WGH. This is caused by that the reinforced autoclaved aerated concrete (RAAC) planks that were used during the construction of WGH becoming insecure with the potential for large pieces to break off and/or planks collapsing into corridors and ward areas. This could lead to an impact/affect on a potential injury or possible death if a sudden collapse of planks were to occur within an occupied area of the hospital. Other impacts include closure of large areas of the hospital to undertake visual inspections and/or remedial works, breaches in statutory duties, negative media coverage, and lose of confidence from stakeholders.
Does this risk link to any Directorate (operational) risks?		1699, 1707	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, staff or public
Inherent Risk Score (L x I):	5x5=25
Current Risk Score (L x I):	1x5=5
Target Risk Score (L x I):	1x5=5
Tolerable Risk:	6
Trend:	*New*

Rationale for CURRENT Risk Score:
The Health Board has engaged specialist structural engineers Curtins to undertake plank by plank visual surveys across WGH which has uncovered a small number of planks that pose a significant risk to safety in 2 wards at WGH. All compromised wards have been decanted as at September 2023, and areas have been secured with authorised access only allowed via keypad entry systems. Other ground floor areas have been fully propped and signed off by the structural engineers as being safe to occupy. Detailed inspection of the planks, to support the work of the visual inspections undertaken to date, are due to commence in October 2023. In addition, assurance has been received on propping design and weekly checks of props are in place. For areas that have yet to be propped, these have been locked off with restricted access. Project plans are in place in terms of when remedial actions will be undertaken, and capital has been secured to fund these works. It is envisaged that all wards will be re-occupied by March 2024. Remedial works on other areas are due to commence in April 2024, with a view to completion by September 2023.

Rationale for TARGET Risk Score:
The target risk score is based on the level risk following visual surveys, propping and remedial works being completed on critical P1 planks identified at WGH.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Specialist structural engineers (Curtins) engaged to undertake a programme of visual inspection of planks at WGH - plank by plank surveys are underway at pace. Process in place to prop identified critical planks within 24 hours to make immediate area safe and to be used or to area to remain closed until safe to re-occupy Principal contractor appointed to provide propping and undertaking remedial works, and assurance has been obtained from the engineers where areas are safe to be re-occupied. Legal advice sought on corporate manslaughter and acted upon promptly. Business Continuity Incident declared on 15Aug23 and Command Control Structure (Gold Silver/Bronze) established to coordinate and manage Health Board response. A Managment Plan to be established to manage the ongoing risks of RAAC, to include: A planned maintenance card is also included in the Maintenance Scheme for the Direct Labour Force to visually check at different point throughout the hospital. Continue to monitor any water ingress on failing roof systems and promptly take any remedial works necessary. During any work above ceiling tiles it has also been passed on to the craftsmen that it is requested that a visual inspection is also carried out. Restriction and controlled access systems in place to certain areas of the	Detailed plank inspections have been undertaken will inform the design specification for remedial works which are due to commence in October 2023 Combination of undertaking visual surveys, propping and remedial works are challenging our ability to deliver safe and effective patient care at WGH (risk 1699).	Detailed plank by plank surveys across WGH by Curtins (dependent on access)	Elliot, Rob	31/03/2024	Viual inspections have been completed, and detailed plank inspections are due to commence in October 2023. Funding has been agreed for remedial works. Remedial works underway in Ward 9 and due to be completed by September 2023, Ward 12 us due for completion by November 2023 and Ward 7 by December 2023 - remaining wards due to be completed by March 2024. Remedial works have been completed in the pot wash area of kitchen.
		Undertaking remedial works resulting from surveys (c£13m)	Elliot, Rob	~~31/08/2023~~ 30/09/2024	Funding has been secured for FY2023/24 and FY 2024/25 for £13m. Remedial works are scheduled to be complete across the site by September 2024
		Development of Management Plan to manage the position/access to areas/staff training until the works being remediated	Elliot, Rob	31/08/2023 Complete	Management Plan has been implemented and monitored via weekly Bronze meetings.

site. Introduced specialist RAAC plank training to provide awareness for site teams and how they should operate where RAAC Planks are identified. Areas have been identified to reduce to loading on the RAAC planks. Weekly inspection of props undertaken on site, and rectified as required. Assessment process in place for service re-occupation to ensure their safety and that the area is able to be used effectively, managed via service site management.		Fast Track Visual Surveys being arranged to identify critical (P1 planks) requiring emergency propping or areas closed off.	Elliot, Rob	30/09/2023 Complete	Fast track visual surveys completed in August 2023.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Command Control Structure (Gold/Silver/Bronze) established	1st			RAAC Update Report to HSC (Jul23) Report to Executive Team (Jul23) RAAC Report to In-Committee Board (Aug23)					
	Reports to Health and Safety Committee (HSC) (bi-monthly)	2nd								
	Reports to Board (bi-monthly)	2nd								
	Specialist Structural Engineer Visual Survey findings	3rd								